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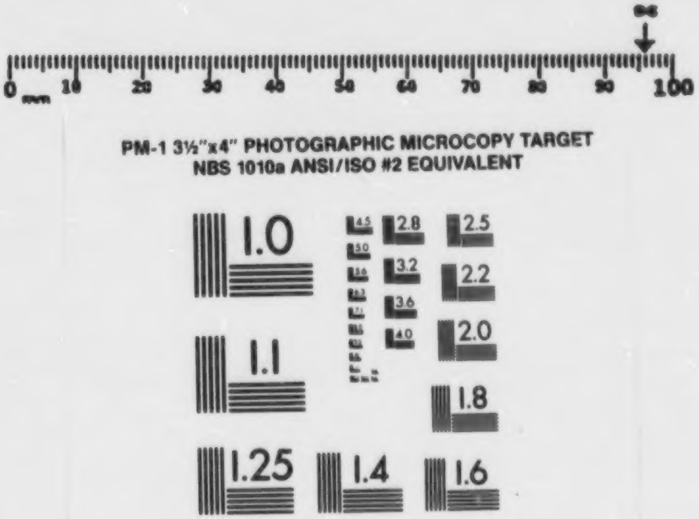

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Annual Report

1997/98 Fiscal Year
Nova Scotia Department of Health
Annual Statistics
as Compiled by the Health
Information and Evaluation Section

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Text Overview

1997/98 Annual Report

Introduction

This Annual Report, compiled by the Health Information and Evaluation Section of the Nova Scotia Department of Health, provides an overview of the Nova Scotia Health System and its components. The information presented in the Annual Report is based on existing data and covers many program areas within the health sector. The programs areas include: Acute Care, Mental Health, Addiction Services, Tobacco Control, Public Health, Home Care Nova Scotia, Emergency Health, and Health Economics.

The Annual Report is intended for distribution to the Senior Management Team and Program Directors of the Nova Scotia Department of Health, the Chief Executive Officers (CEO's) of the Region Health Boards (RHB's) and Non-Designated Organizations (NDO's).

1. Acute Care Services

There is a wealth of data available on acute care programs and services especially when compared to other sectors of the health care system. Data on acute care services in Nova Scotia have been collected for more than twenty years and comparative interprovincial data have been available since 1995 when Nova Scotia began reporting health information to the Canadian Institute for Health Information (CIHI).

Several traditional indicators of efficiency are reported for the acute care sector - patient days, day surgery rates and procedure volumes.

a. Patient Days and Bed Numbers

Throughout the country patient days and days per thousand have decreased during this decade and this pattern is seen in the Nova Scotia rates. Eastern Region residents and hospitals have the highest volume of patient days in the province; Central region residents, the lowest.

Even with this decrease, Nova Scotia's days per thousand population are higher than most other provinces. Each province defines 'acute care' independently so caution is necessary when making interprovincial comparisons. Provinces, such as Ontario, with chronic care beds and/or facilities have lower acute care patient days per thousand, for example. The inclusion or exclusion of acute care psychiatric days in the acute care database is also a provincial decision and, thus, may affect provincial rates.

Acute care beds have also been decreasing through this decade. Interprovincial comparisons for 1997/98 show that Nova Scotia is at about mid-point at 3.4 beds per 1000 population.

b. Average Length of Stay, Alternative Level of Care, and May Not Require Hospitalization (ALOS, ALC, and MNRH)

More than 8% of the separations and 5% of the acute care days in Nova Scotia are classified as May Not Require Hospitalization (MNRH) i.e., these services could possibly be provided more appropriately in another setting, such as a medical day unit or day surgery clinic. Case Mix Group *(CMG) 063 Tonsillectomies and Adenoidectomies* represents the highest volume of MNRH's. Transurethral prostatectomies (TURPs), transurethral resections of bladder tumors (TURBT's), cystoscopies and adjustment disorders are other common MNRH separations from Nova Scotia hospitals.

The average acute care length of stay (ALOS) has decreased gradually since 1993 with a slight increase in 1997/98. Nova Scotia has the second highest average length of stay in Canada at 7.8 days. Manitoba has highest at 9.6 days and Alberta, the lowest, with 5.9 days.

There is significant debate about the usefulness of overall average length of stay as an indicator. Lengths of stay for particular patient groups, especially when compared with other facilities or expected lengths of stay, are more commonly used for utilization management at the facility or regional level.

Alternate Level of Care (ALC) Days are days of care provided to inpatients who have finished the acute care phase of their treatment or who were admitted for non-acute medical care. The physician or designate must identify a patient as ALC. Differences in rates between facilities, regions, and provinces may reflect differences in reporting practices rather than differences in hospital utilization or patient mix.

c. Same Day Admission Surgery, Day Surgery, and Selected Surgical Procedures

Comparisons of the utilization of surgical services are long-standing measures of efficiency and appropriateness. Limits on the availability of elective beds have decreased lengths of stay and the movement of selected surgical procedures to the day surgery setting has also improved patient satisfaction. Performing surgery on the day of admission helps to decrease the length of stay. The percentage of elective surgeries performed on the day of hospital admission has increased from 7% in 1990/91 to 72% in 1997/98. Eastern and Northern Region hospitals have met the provincial target this fiscal year.

An increasing number of surgeries have been moved from the inpatient to the day surgery setting. As a percentage of all surgery (urgent, emergent, and elective), the percentage performed in day patient surgery has increased from 51% in 1990/91 to 70% in 1997/98. There is little variation among the regions. A provincial target of 75% had been set in the early 1990's. Nova Scotia's rate is slightly below that of other provinces reporting Day Surgery to the Canadian Institute for Health Information (CIHI).

Day surgery rates can be calculated in several ways in addition to CIHI's method, noted above. One way is to include only in-patient and day surgery *elective* surgeries in the calculation. The percentage of surgery performed on a day surgery basis increases when this method is used.

A review of specific procedures highlights the changes in surgical practices. Inguinal hernia repairs are increasingly performed in day surgery units, especially at regional and tertiary facilities. Over 95% of all cataract extractions are performed as day surgeries. Laparoscopic cholecystectomies account for about 80% of all cholecystectomies compared with 65% in 1992/93 and the percentage performed in day surgery using this approach has also increased. In 1997/98 over 98% of carpal tunnel releases were day surgeries.

In an attempt to adjust for differences in the population distributions of the four regions, age standardized rates have been used. Total knee and total hip replacement rates show some fluctuation over time and differences between regions. Northern Region residents have the highest rate of hip replacements in Nova Scotia and the Eastern Region, the highest rate for knee replacements. Where Canadian data are provided they show rates for Nova Scotia that are greater than the national average. Both the crude and age-standardized hysterectomy rates have declined since 1994/95. In Nova Scotia, Western Region residents have the highest rate per 100,000 population.

d. Cardiovascular Procedures

Access to cardiac surgery is monitored by the Divisions of Cardiology and Cardiovascular Surgery at the QEII and waiting times for these procedures are reported to the Department of Health on a monthly basis. During 1997/98 patients waiting for cardiovascular procedures on an elective or semi-urgent basis have waited longer than the standard period while waiting times for urgent surgery have generally been less than the one week standard.

The age-standardized rates for cardiac catheterizations and coronary angioplasties have declined since 1994/95 and 1992/93 respectively. Central Region residents have the highest rates for these surgical procedures. The rate of coronary artery bypass grafts has remained relatively stable over the past three years at roughly 76 per 100,000 population.

e. Readmissions to Hospital

Hospital readmission rates have been used to measure the effects of decreasing bed numbers and lengths of stay. The Canadian Institute for Hospital Information (CIHI) measures readmissions to the same hospital with the same or related diagnosis within 7 and 30 days of hospital discharge. The accuracy of reporting at the hospital level has been a concern and this is gradually being improved. Variations in regional rates may reflect reporting inconsistencies. The provincial readmission rate is 3.8% for one week and 10.2 % for one month readmissions respectively. Hospitals in the Eastern Region have the highest rates for both measures of readmission. Obstetrical cases and newborns are excluded from this indicator. For fiscal 1999/2000, hospitals have begun collecting readmission data on the basis of whether that readmission was *planned* or *unplanned.* It is recognized by CIHI that reporting on readmissions to *any* hospital rather than to one facility, while a difficult data processing issue, would be a more useful indicator.

2. Mental Health Programs

The World Health Organization, in reflecting on the global burden of disease, has noted that five of the top ten causes of disability as measured by severity and duration are mental illnesses. Twenty-six percent of workers report stress and mental or emotional health problems as a result of their work (as opposed to 9% for other injury or illness) costing business and employees an estimated $5 billion dollars per year in Canada. Over 18% of children have at least one diagnosable psychiatric disorder.

- Mental Health Services, NSDoH

a. Inpatient Separations, Patient Days and Length of Stay

Inpatient acute care separations and patient days are ways to measure the utilization of mental health programs. The volume of separations for diagnostic groups, e.g. Mood Disorders, shows the likelihood of encountering certain conditions in the clinical setting. The Nova Scotia Hospital and in-patient units in several regional facilities provide in-patient mental health programs.

In 1997/98 the most often encountered diagnostic groups for adults (19 years of age and older) were mood disorders; schizophrenia and psychotic disorders; adjustment disorders; substance related disorders; and anxiety disorders. For children, the diagnoses most commonly treated on in-patient units were: mood disorders; attention-deficit and disruptive behaviour disorders; adjustment disorders; substance related disorders; and schizophrenia and psychotic disorders. These diagnoses also utilize the greatest number of patient days.

Nationally and provincially, the average length of stay for adults in acute psychiatric care (excluding forensic and extended care units) has been decreasing. Central Region residents have the longest average length of stay in the province (20 days) and Northern (9 days), the lowest.

b. Outpatient Clinics and Ambulatory Care (Youth and Adults)

Outpatient mental health clinics treated almost 25,000 clients in 1997/98. The most common diagnoses treated in these clinics were mood disorders; miscellaneous anxiety disorders; schizophrenia and adjustment disorders. For clients under the age of 18 the most frequent diagnoses were adjustment disorders; attention deficit/hyperactivity disorder; relation abuse; and emotional disturbance.

Although slightly more people were treated on an ambulatory basis in 1996/97 than in 1997/98, there has been an overall increase in ambulatory care program utilization since 1993/94. The number of visits per client to ambulatory care programs has remained relatively stable.

3. Addictions Services

a. Number of Clients Served by Gender and Service Utilization Breakdown

The data regarding the number of clients in Addiction Services programs illustrates a steady increase in the utilization of services since 1992/93 for both men and women. While men utilize addiction services programs more frequently than do women, there has also been a steady increase in program use by women.

The information on service breakdown for 1997/98 shows that Outpatient Services (O.P.S.) and Detoxification Services were the most utilized programs in Addiction Services.

4. Public Health Programs

The percentage of women known to be breast feeding at the time of hospital discharge has increased steadily since 1988. However, in 1997, Nova Scotia women were breast feeding at a rate of 63% which is both less than the Canadian 1994 rate (74%) and the Nova Scotia year 2000 target rate (75%).

The percentage of senior citizens vaccinated against influenza increased gradually prior to 1995/96. Even though the rate has declined in the past few years, Nova Scotia is still quite close to meeting the national target level of 65%. Changes in how immunizations are reported may partially account for the decrease in rates.

As well as tracking health promotion activities such as vaccinations and breast feeding, Public Health programs also monitor the rates of infectious diseases in Nova Scotia. For example, chlamydia rates have steadily declined since 1991 and the incidence rate of AIDS has also decreased since 1994. The rate of HIV incidence has remained fairly stable.

5. Tobacco Control

Tobacco use is the number one public health problem adversely affecting Nova Scotians. Over 1400 Nova Scotians die annually as a direct result of smoking and it is estimated that another 80 Nova Scotians die due to exposure to second-hand smoke. Nova Scotia men and women have the second highest rates of lung cancer mortality in the country (1998 National Cancer Institute, Cancer Statistics Annual Report).

The Tobacco Control Unit works in partnership with schools, businesses, provincial and community organizations, and other government departments (e.g. Education, Finance, Tourism), to deliver a comprehensive tobacco control strategy for the province. Key components of this strategy are: Public Education; Legislation/Policy and Enforcement; Health Promotion Programming; and Resources, Training, Monitoring, and Evaluation.

For example, all school boards in the province have had in-service workshops on a Smoke-Free for Life Tobacco Education Curriculum for grades Primary to 9. The province's three tobacco control inspectors carry out the enforcement of the Tobacco Access Act prohibiting tobacco sales to minors under 19 years of age, as well as enforcing Federal tobacco legislation. One monitoring aspect of the tobacco enforcement program is the measure of the degree to which tobacco retailers are complying with the Nova Scotia Tobacco Access Act.

Smoking rates are high among the adult Nova Scotian population (29.0%), among pregnant women (27.6%); and among youth (36.1%). The prevalence of environmental tobacco smoke (ETS) is a concern to non-smokers and health professionals alike. While Nova Scotia's rate for persons living with a smoker who regularly smokes indoors is comparable with the other Atlantic Provinces, it is still quite high – 39.7% (in 1996/97).

In 1997/98, 31% of Nova Scotia's 2800 retailers inspected were found to be in compliance with the law. Where more concentrated inspections were made, the compliance rate rose to just over 50% (Northern Region).

6. Home Care Nova Scotia

a. Caseload, Admissions, and Home Oxygen

Across the province, Home Care Nova Scotia has experienced a gradual increase in the numbers of clients since 1995/96 volumes vary regionally. In 1997/98 Central Region, which has the highest population, also had the greatest number of clients (5565) while Northern Region had the lowest (3119). Although the total percentage change of Home Care Nova Scotia admissions since 1996/97 was positive, the Regions showed marked variation. The total number of admissions to Home Care Nova Scotia also varied by quarter and by Region.

Home Care Nova Scotia has two service components: chronic Home Care services and acute Home Care services. Chronic Home Care services are designed to meet the assessed needs of clients needing long-term care, whereas acute Home Care services are designed to meet the needs of those people leaving hospital who need immediate help for a relatively short period of time.

Chronic Home Care services had more admissions than acute Home Care services in all Regions over the last three fiscal years. The number of admissions to acute Home Care services, in most of the Regions, has steadily increased since 1995/96 with Central Region showing the greatest increase in admissions during the last three quarters of 1997/98.

Home oxygen is provided through chronic Home Care services. Central Region had the most clients receiving home oxygen (152) and Northern Region had the fewest (78).

7. Emergency Health Services

a. Government Subsidized Patient Transfers and Out of Hospital Cardiac Arrest Survival Rates

Emergency health services that are provided by Nova Scotia Emergency Health Services, are funded by the Department of Health and through users' fees. The volume of activity is measured through government subsidized patient transfers. Patient transfers of less than 160 kilometers are considered local; those over 160 kilometers are termed long distance. The volume of local emergency medical ambulance service increased during 1997/98; long distance volumes remained constant.

Response times from the moment a call is received, to the dispatching of an emergency vehicle, to the vehicle's arrival at the emergency scene are each critical to the victim's well-being and/or survival in an emergency situation. Nova Scotia Emergency Health Services has demonstrated a consistent response time of around 1 minute 8 seconds from call to dispatch. Emergency Health Services has decreased the time from dispatch to arrival at scene from 10 minutes 29 seconds at the beginning of 1998 to 8 minutes 55 seconds by the end of 1998. The number of emergency and non-emergency transports indicate vehicle utilization and the number of both types of transports has increased during 1998.

Knowing what types of emergency situations are encountered by Emergency Health Services personnel can help them prepare for future needs. In 1998 the top five chief complaints from emergency calls were (in descending order): breathing problems; traffic accidents; fall/back injuries; chest pain; and 'sick persons'.

Emergency Health Services receives and responds to more than 500 out-of-hospital cardiac arrest calls per year. Successful treatment of out-of-hospital cardiac arrests requires the immediate response of trained paramedics and first responders. Survival means that the victim remains neurologically intact and regains cardiac rhythm. In 1997, Emergency Health Services had a 4% survival rate. In 1998, 3% of out-of-hospital cardiac arrests survived. For the year 2000, Emergency Health Services has set 8% as their target for out-of-hospital cardiac arrest survivors.

8. Expenditures for Insured Services

Insured services includes medicare, pharmacare, and denticare programs. Since 1991/92, expenditures on these programs have risen slightly.

a. Medicare

Medical expenditures can be measured by examining the cost and number of services provided by physicians to patients. Although in 1995/1996 the number of physicians' services per beneficiary (a beneficiary is a person with a Nova Scotia Health Card Number who has received services during the fiscal year) began a slight downward trend, the overall level has remained relatively constant. The expenditure for physician services per beneficiary has shown an upward trend since 1990/91.

In 1996/97 there were, on average about 1000 insured persons for every licenced general practitioner in Nova Scotia. Overall, there are more general practitioners in urban than in rural areas.

b. Pharmacare

The number of prescriptions per beneficiary and the cost of those prescriptions can show changes in Pharmacare program utilization. The number of prescriptions and expenditures per beneficiary have increased slightly since 1994/95 while the overall number of prescriptions per beneficiary has remained relatively constant.

c. Denticare

Denticare, under the auspices of The Nova Scotia Children's Oral Health Program, funds a range of dental health services to children under of age of 10. In Nova Scotia the percentage of young children (3 to 9 years) receiving annual dental check-ups decreased in 1997/98. Central region rates were higher than those of the other regions.

The average number of restorations per insured also decreased. Western Region residents had the highest average number of dental restorations per insured.

9. Women's Health

a. Caesarean Sections, Breast Cancer Screening/Breast Cancer Mortality, and Cervical Cancer Screening/Cervical Cancer Rates

Caesarean sections, breast screening, breast cancer mortality, and gynaecological cancer screening and mortality rates have been chosen to illustrate some women's health issues.

The rate of Caesarean sections per 100 deliveries has been increasing since 1969/70. In 1997/98 the rate varied between the regions -- Central Region hospitals have the highest rate (20%) whereas Northern Region has the lowest (17%). The IWKGrace provides obstetrical services for high-risk deliveries and, therefore, a higher percentage of Caesarean sections at that facility should not be unexpected.

The percentage of women aged 50 to 69 who were screened for breast cancer has increased to 5.7% in 1997/98 from 4.3% in 1997/97. The percentage of women screened in Nova Scotia is low. The breast cancer mortality rate was 25 deaths per 100,000 women in 1950 and has been increasing since then to 33 per 100,000 women in 1997.

Gynaecological cancer screening rates in Nova Scotia have remained relatively constant across the regions. While approximately 44% of women over 15 years of age in Central Region had Papanicolaou exams (PAP smears) during the past year; only 32% of Eastern Region women were screened.

In Nova Scotia the cervical cancer incidence rate has been decreasing over time. However, the mortality rate has increased from 3.4% in 1994 to 4.2% in 1997. While Nova Scotia's mortality rate is increasing, the national rate is falling.

10. Mortality in Nova Scotia

In addition to measures of morbidity, mortality rates can be useful in describing the overall health of a population. Nova Scotia's mortality rates show a slight decline since 1990 for the various disease conditions reported, despite some variations between regions and over time. Among the regions, considerable fluctuations around the provincial rate occur. Eastern Region rates tend to be higher than those for the other regions for all reported conditions with the exception of accidents and adverse effects.

11. Procedure Rate Variation

Procedure rates for 1997/98 also show variations across the province. County level analysis of procedure rates may help identify differences in practice patterns. While these small area variations may be due to differences in disease occurrence or treatment methods it should be noted that they are based on the patient's county of residence and not the hospital in which the treatment was provided.

Laparoscopic cholecystectomy rates are highest for Digby County; hysterectomy rates are highest in Queen's and King's Counties. Yarmouth County has the highest rates for bilateral myringotomy and tubes; Cumberland county has the highest rates of colonoscopies and cataract extractions in Nova Scotia; and Coronary artery bypass grafting rates are highest among Annapolis county residents.

12. Conclusion

These indicators have provided a brief overview of Nova Scotia's health care system in 1997/98. Any comments, questions, or requests for additional copies should be directed to Barbara Harvie (424-0972) at the address below.

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Halifax, Nova Scotia
B3J 2R8

Slide Show

ANNUAL REPORT

1997/98

ANNUAL REPORT - DATA NOTES

A Guide to Using the Data

- The Report is Designed to be Read in the Following Order: Overview, Slides, and Dictionary.
- Each Slide has Information on its Background, its Formula, and Its Source as well as a Context Specific Overview.
- The Data Dictionary Explains All Data Variations and Formula Inclusions and Exclusions.
- For an Overview of the Data Presented in this Slide Show, Please See the Text Overview Immediately Before this Slide Show
- For Information on How to Read the Data or How the Data were Derived, Please See the Data Dictionary Immediately After this Slide Show.

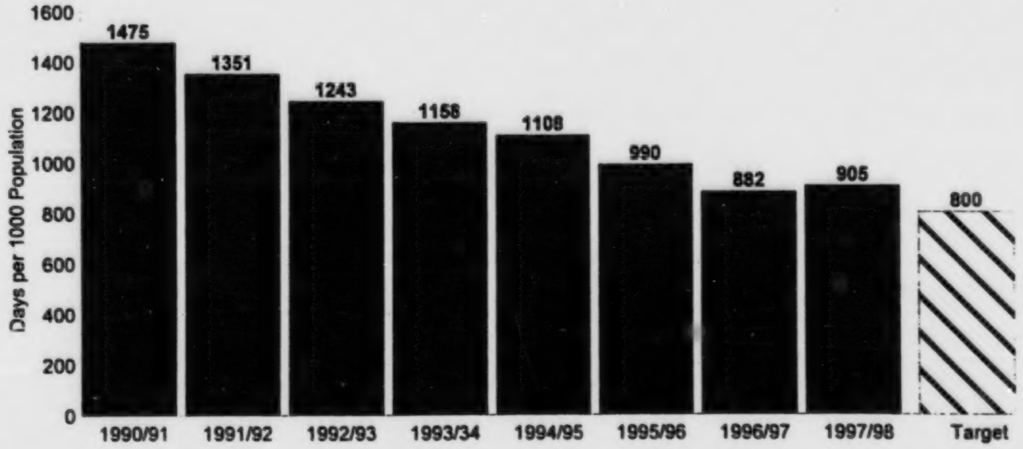
ACUTE CARE

Part One

- Patient Days
- Hospital Beds
- Average Length of Stay
- Alternate Level of Care
- May Not Require Hospitalization Days (MNRH)

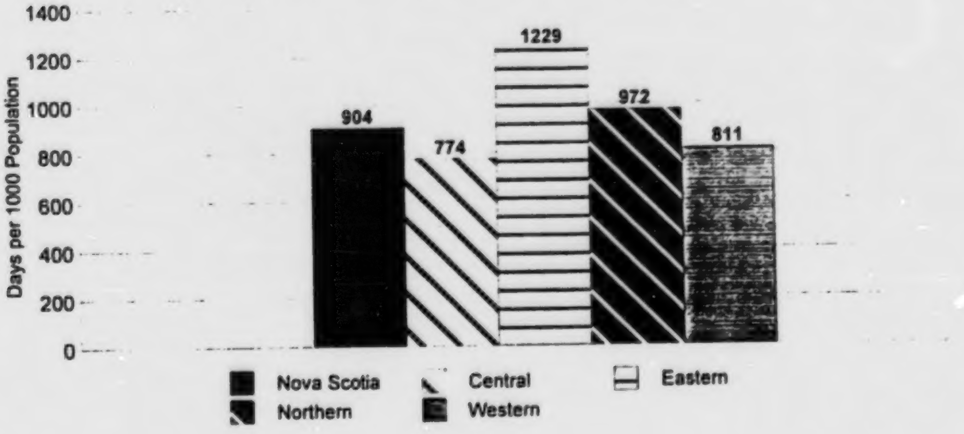
PATIENT DAYS PER 1000 POPULATION

Nova Scotia - 1990/91 to 1997/98



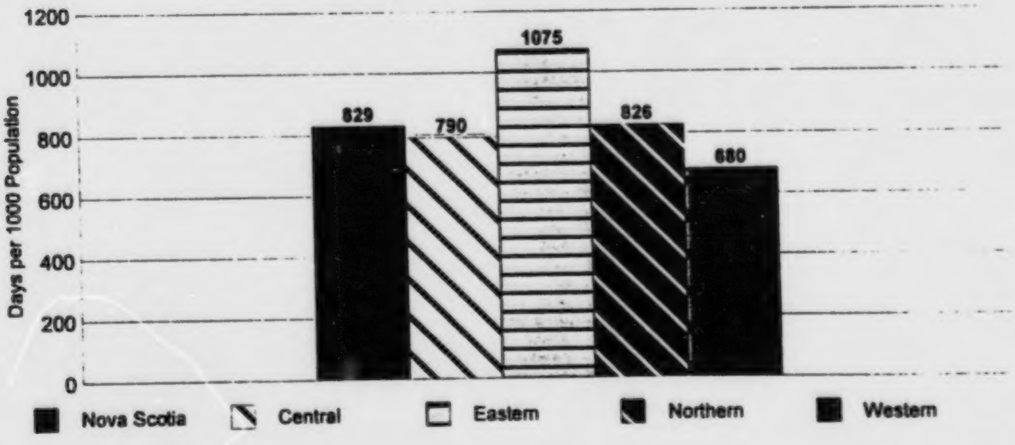
PATIENT DAYS PER 1000 POPULATION

Crude Rates per 1000 Population by Region of Residence
1997/98 - Excludes Newborns



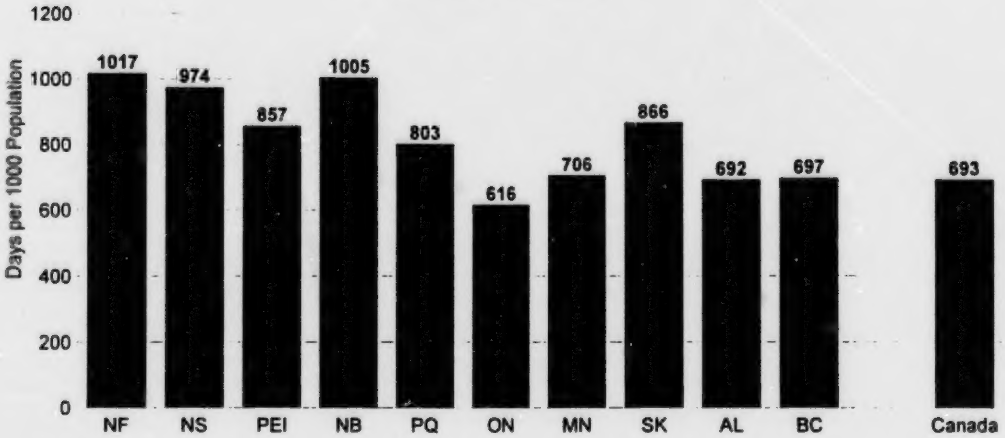
PATIENT DAYS PER 1000 POPULATION

Rates per 1000 Population Age-Standardized to the 1991
Canadian Population -by Region of Residence -1997/98 -
Excludes Newborns



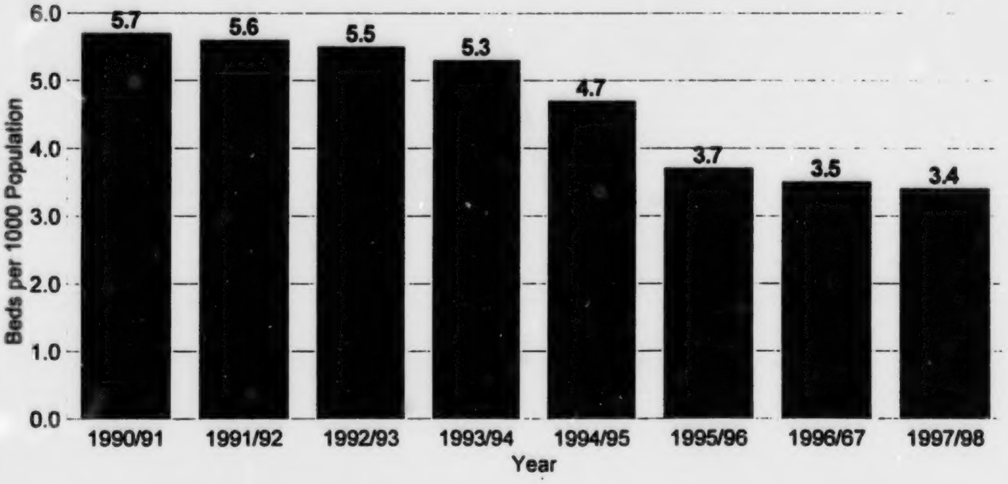
PATIENT DAYS PER 1000 POPULATION

Interprovincial Comparisons 1997/98
Quebec 1996/97



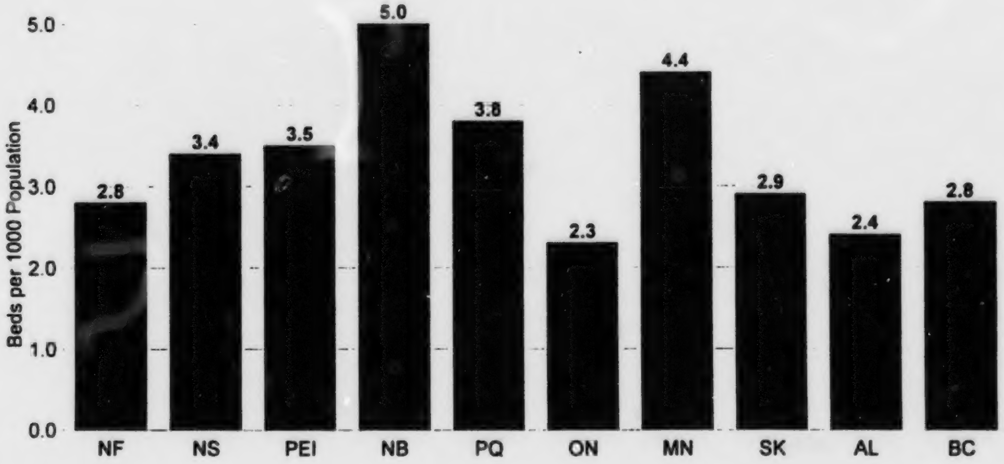
BEDS PER 1000 POPULATION

Nova Scotia 1990/91 to 1997/98



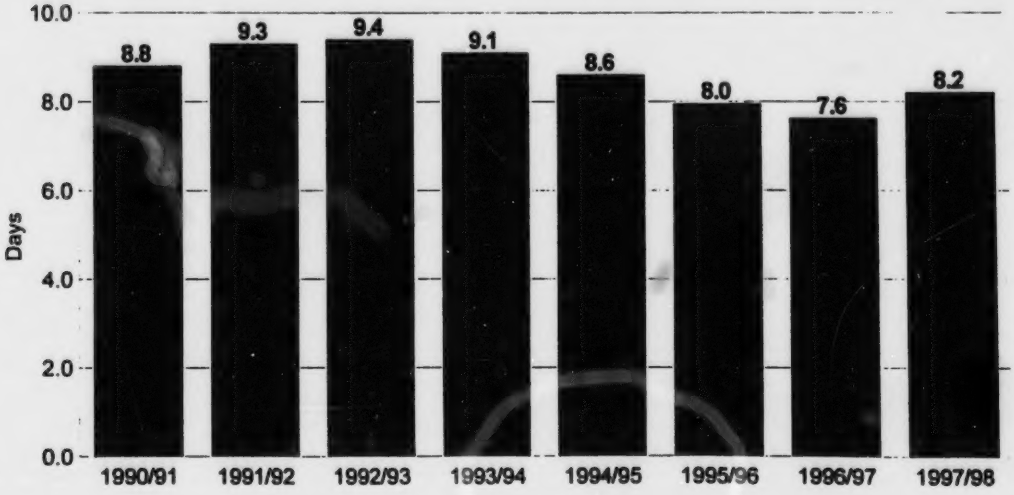
BEDS PER 1000 POPULATION

Interprovincial Comparisons
Nova Scotia 1997/98 and Other Provinces 1996/97



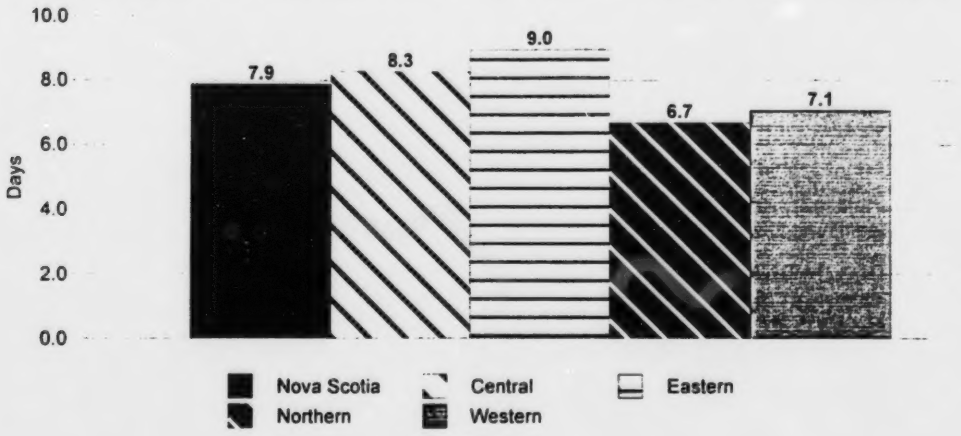
AVERAGE LENGTH OF STAY

Acute Care
Nova Scotia - 1990/91 to 1997/98 - Excluding Newborns



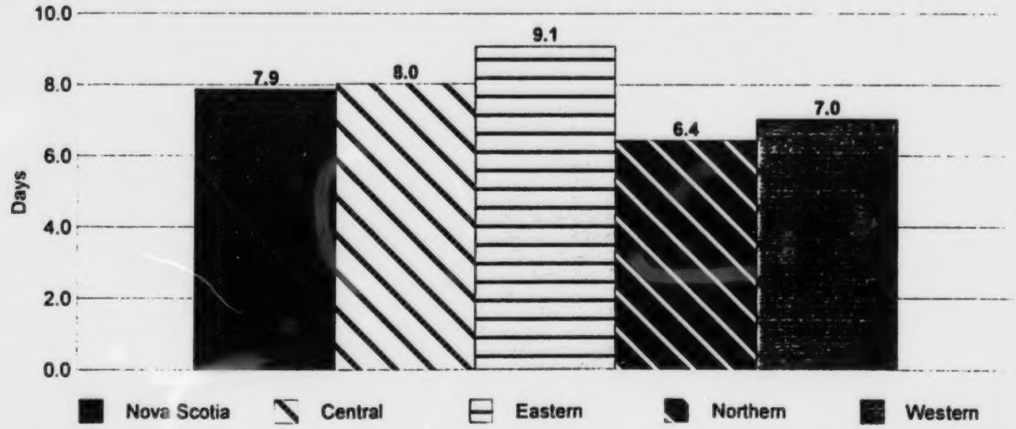
AVERAGE LENGTH OF STAY
1997/98

Acute Care
by Region of Residence - 1997/98 - Excluding Newborns



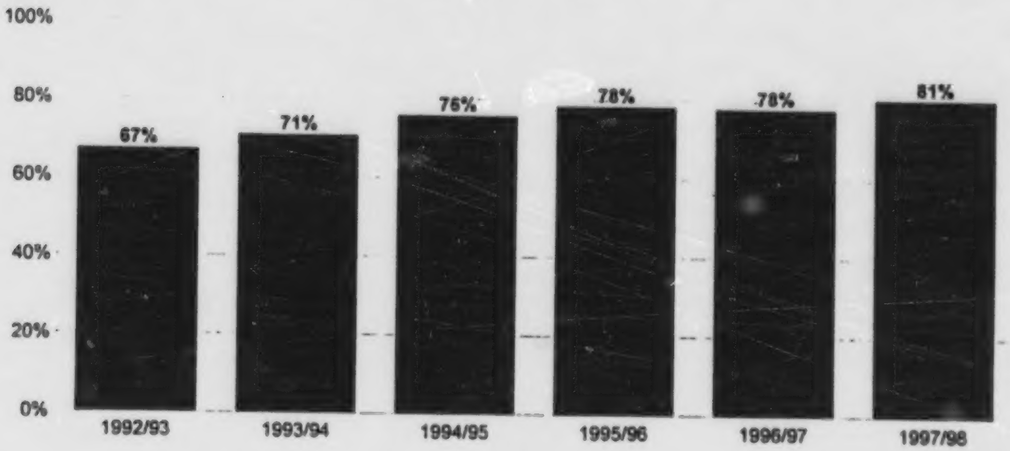
AVERAGE LENGTH OF STAY
1997/98

Acute Care by Region of Hospitalization - 1997/98
Excluding Newborns



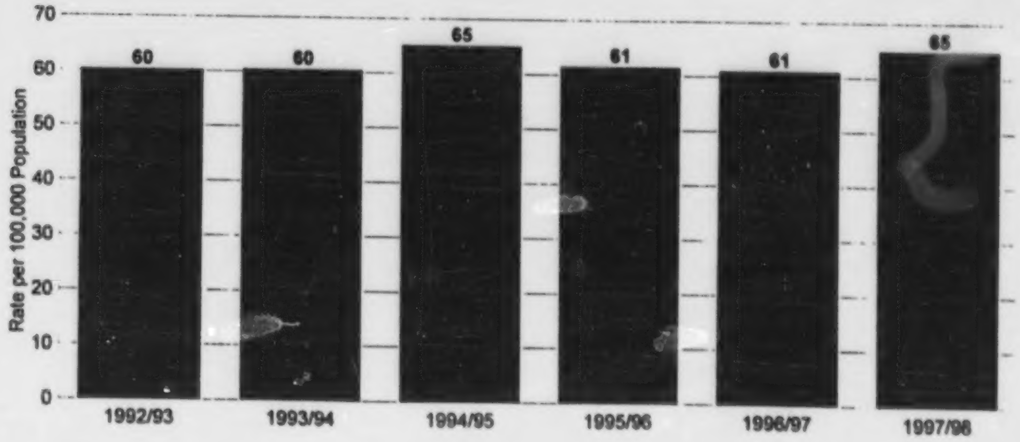
LAPAROSCOPIC CHOLECYSTECTOMIES

As a Percentage of All Cholecystectomies - Nova Scotia
1992/93 to1997/98



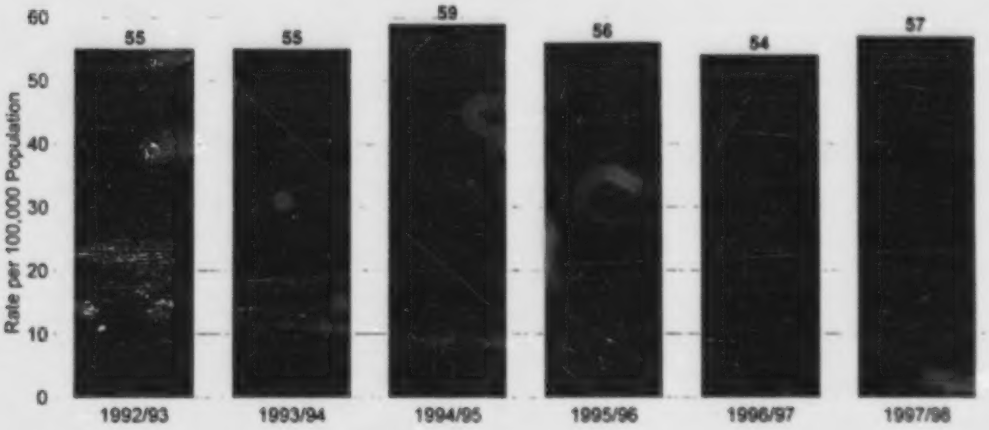
TOTAL HIP REPLACEMENTS

Crude Rates per 100,000 - Nova Scotia - 1992/93 to 1997/98



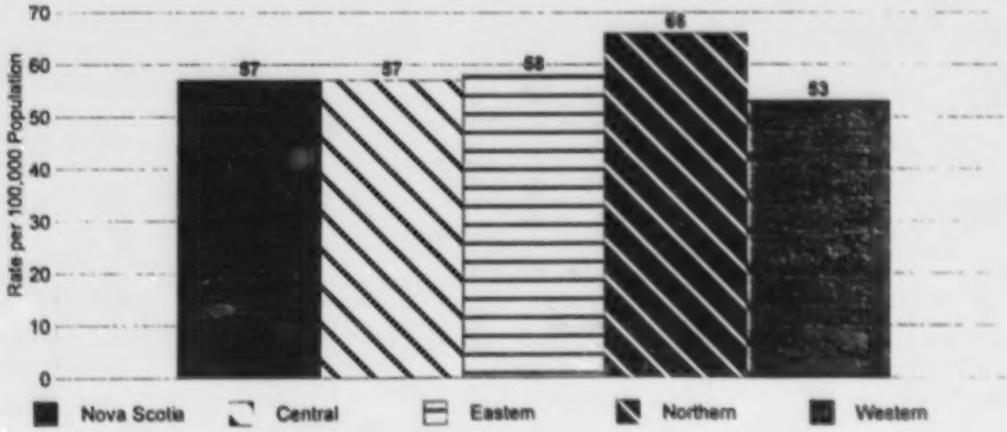
TOTAL HIP REPLACEMENTS

Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia 1992/93 to 1997/98



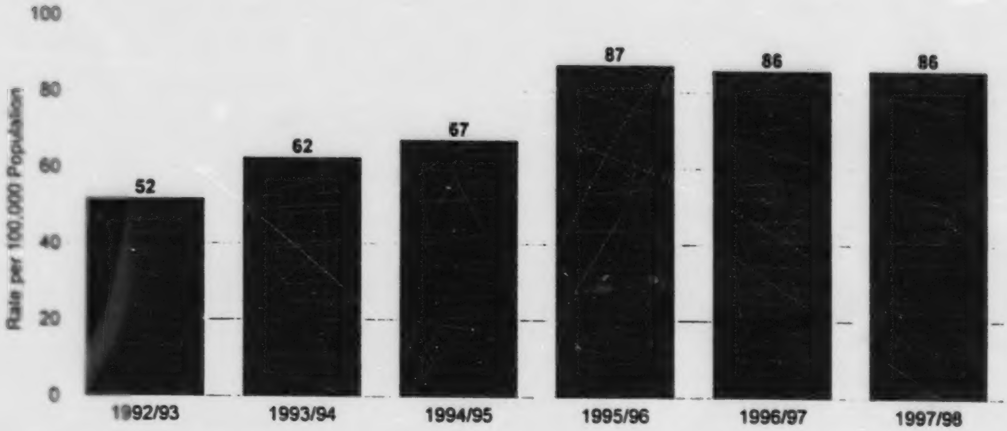
TOTAL HIP REPLACEMENTS

1997/98 by Region of Residence Rates per 100,000 Age-Standardized to the 1991 Canadian Population



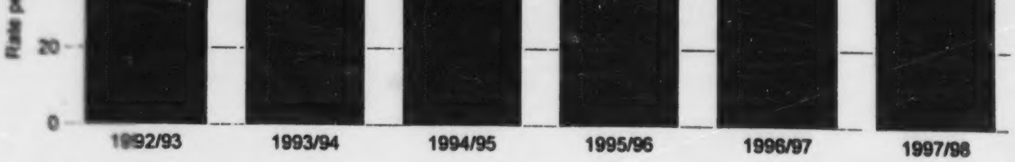
TOTAL KNEE REPLACEMENTS

Crude Rates per 100,000 - Nova Scotia - 1992/93 to 1997/98



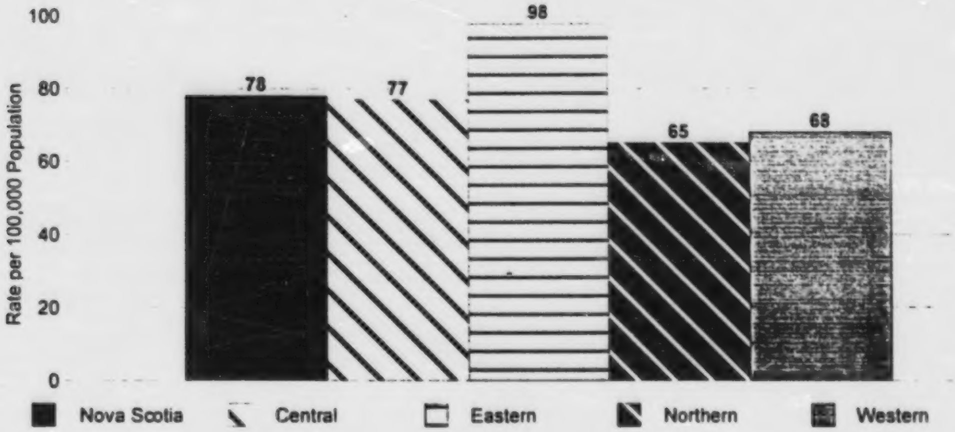
TOTAL KNEE REPLACEMENTS

Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia 1992/93 to 1997/98



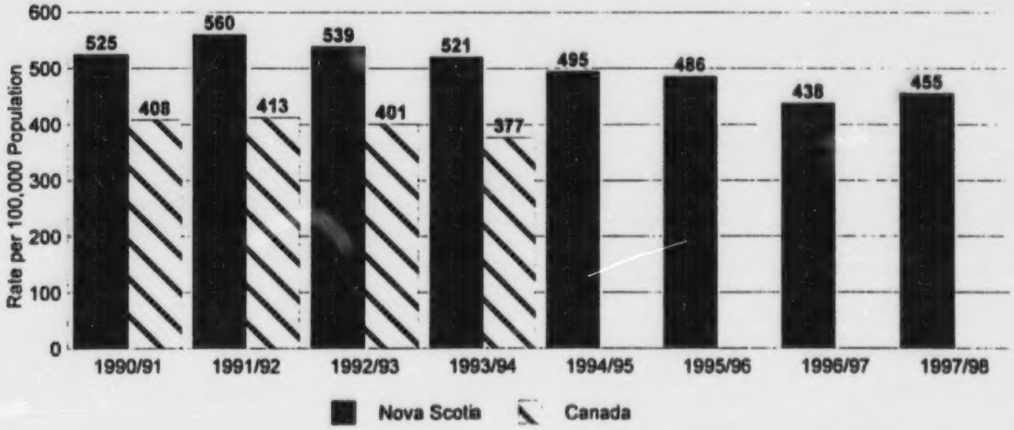
TOTAL KNEE REPLACEMENTS

1997/98 Rates per 100,000 by Region of Residence
Age-Standardized to the 1991 Canadian Population



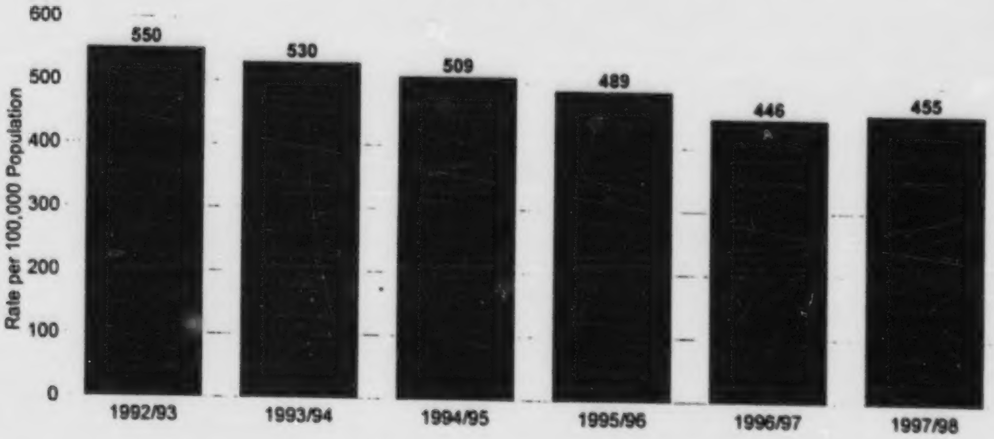
HYSTERECTOMIES CANADA AND NOVA SCOTIA

Crude Rates per 100,000 Population



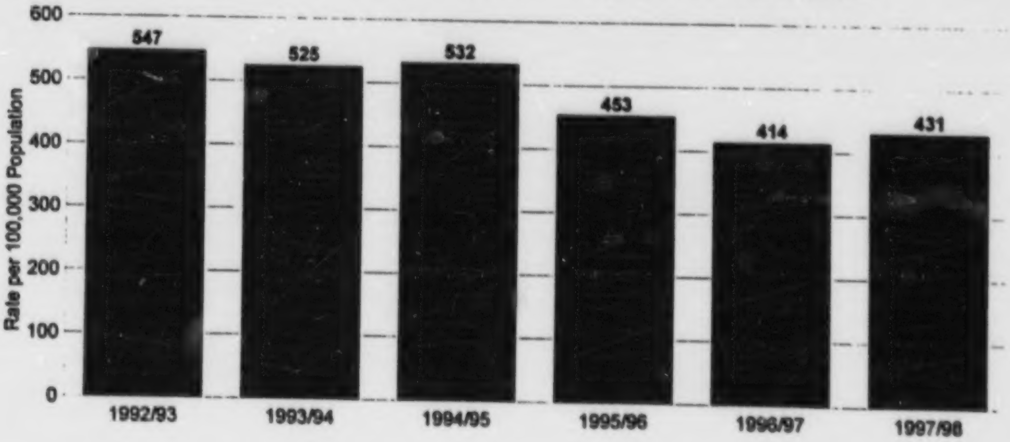
HYSTERECTOMIES

Crude Rates per 100,000 - Nova Scotia - 1992/93 to 1997/98



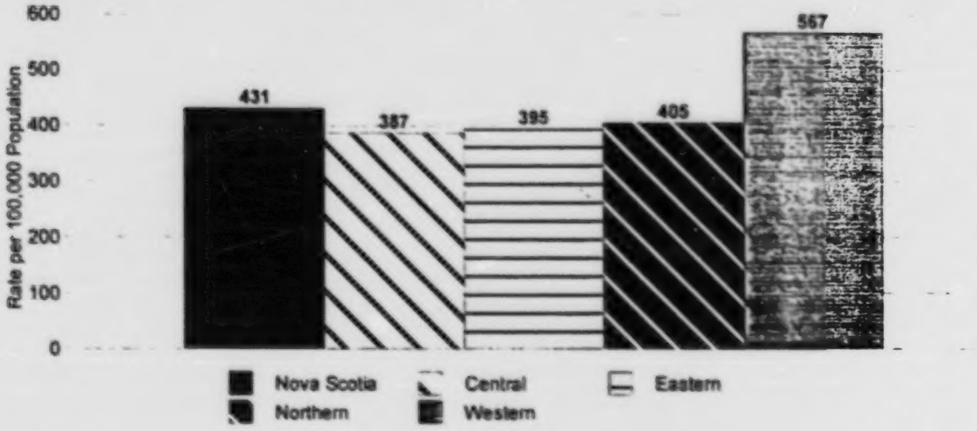
HYSTERECTOMIES

Rates per 100,000 Age Standardized to the 1991 Canadian Population - Nova Scotia 1992/93 to 1997/98



HYSTERECTOMIES

By Region of Residence - 1997/98 Rates per 100,000
Age-Standardized to the 1991 Canadian Population



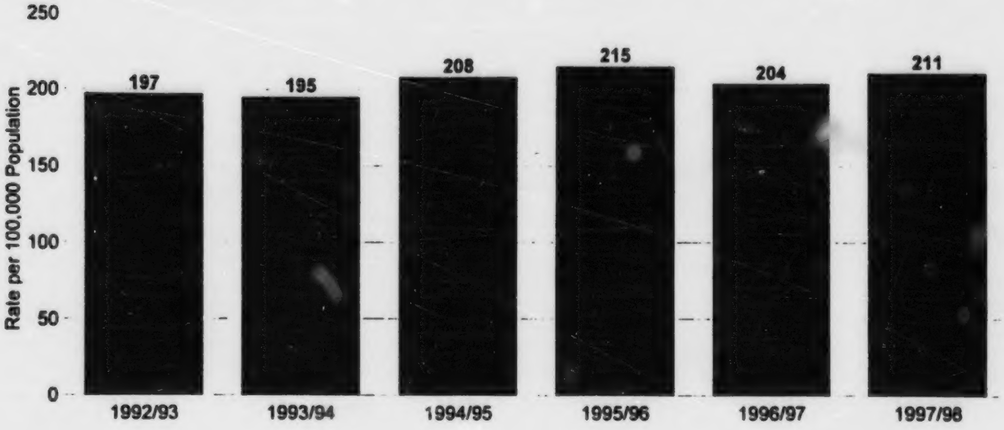
ACUTE CARE

Part Three

- Cardiovascular Surgery
- Readmissions to Hospital
- ‘Top Ten’ ICD-9-CM Diagnostic Chapters

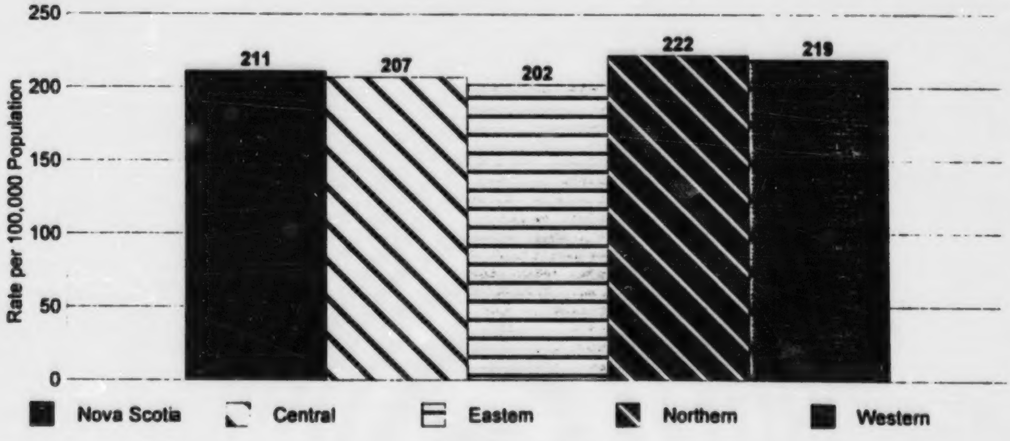
CARDIAC CATHETERIZATIONS

Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia 1992/93 to 1997/98



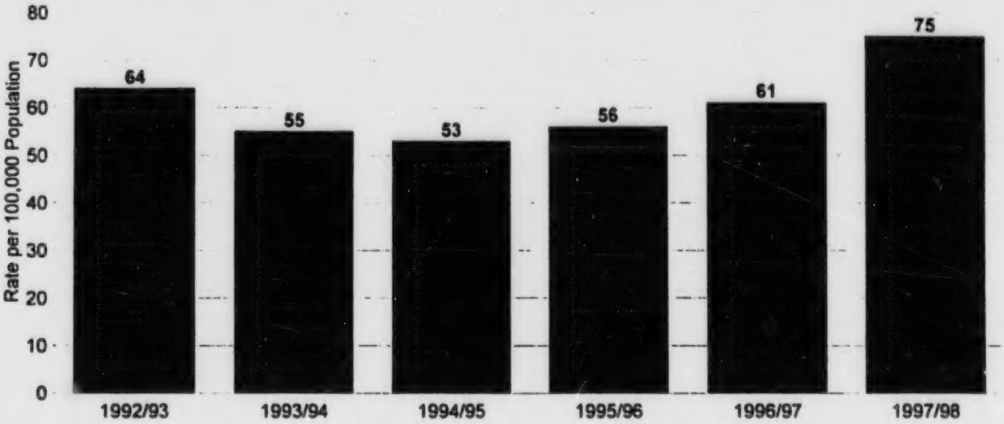
CARDIAC CATHETERIZATIONS BY REGION OF RESIDENCE

1997/98 Rates per 100,000
Age-Standardized to the 1991 Canadian Population



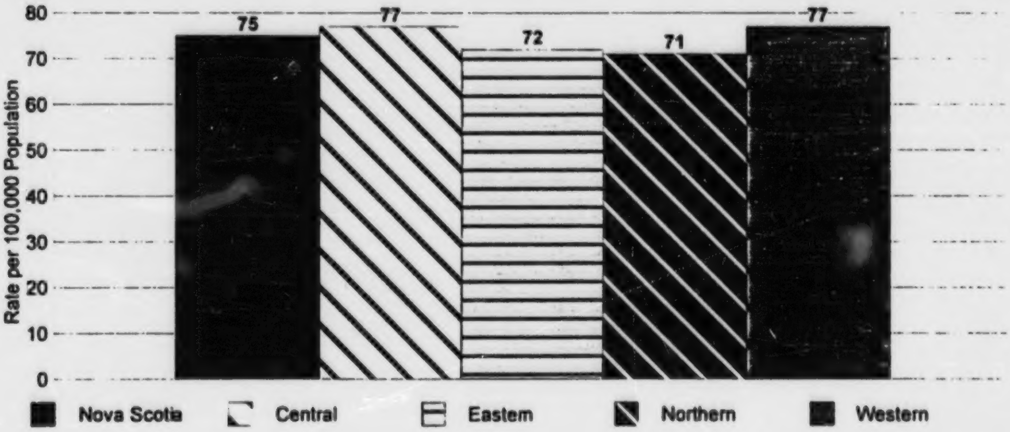
CORONARY ANGIOPLASTIES

Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia 1992/93 to 1997/98



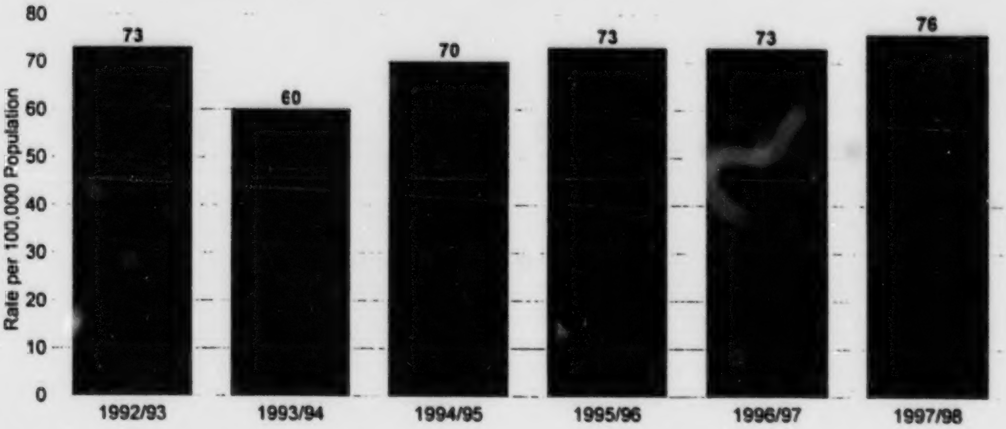
CORONARY ANGIOPLASTIES BY REGION OF RESIDENCE

1997/98 Rates per 100,000
Age-Standardized to the 1991 Canadian Population



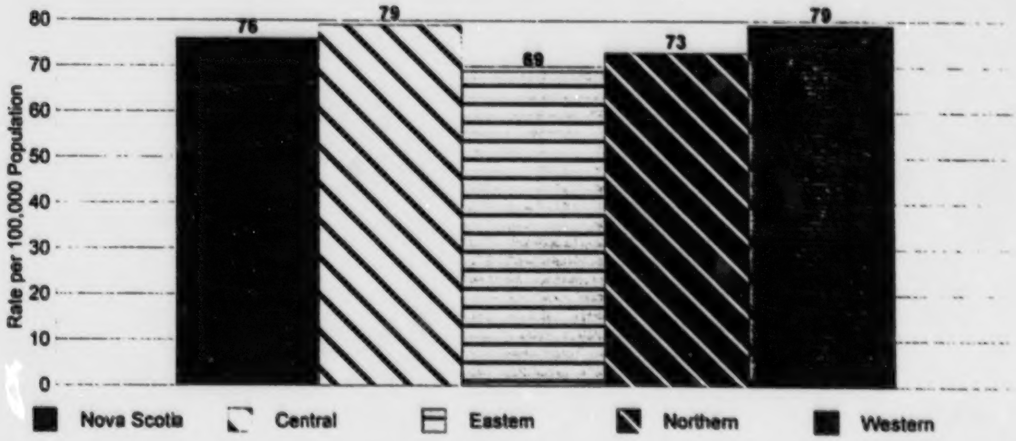
CORONARY ARTERY BYPASS GRAFT

Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia 1992/93 to 1997/98



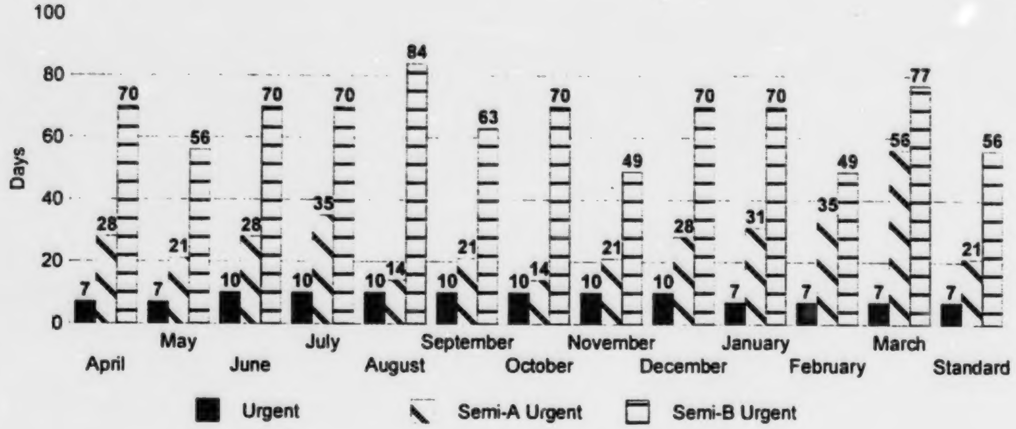
CORONARY ARTERY BYPASS GRAFT BY REGION OF RESIDENCE

1997/98 Rates per 100,000
Age-Standardized to the 1991 Canadian Population



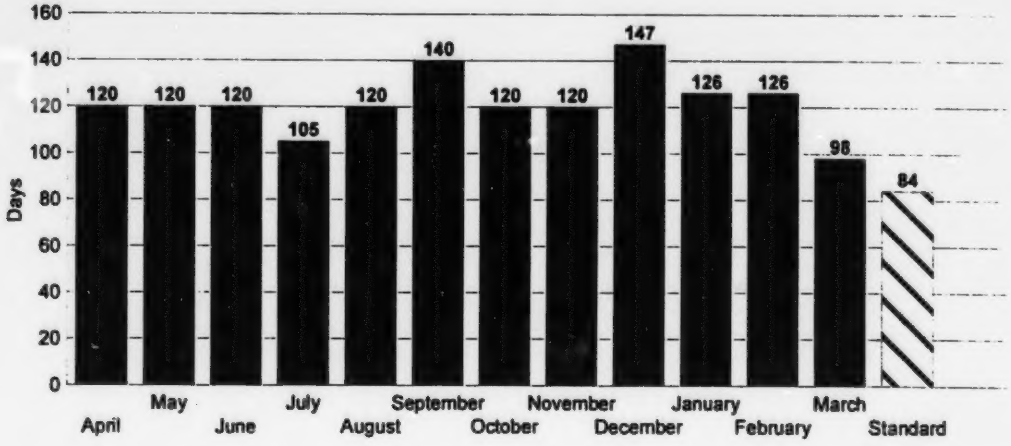
CARDIOVASCULAR SURGERY WAIT TIMES (URGENT)

by Category and Month - April 1997 to March 1998



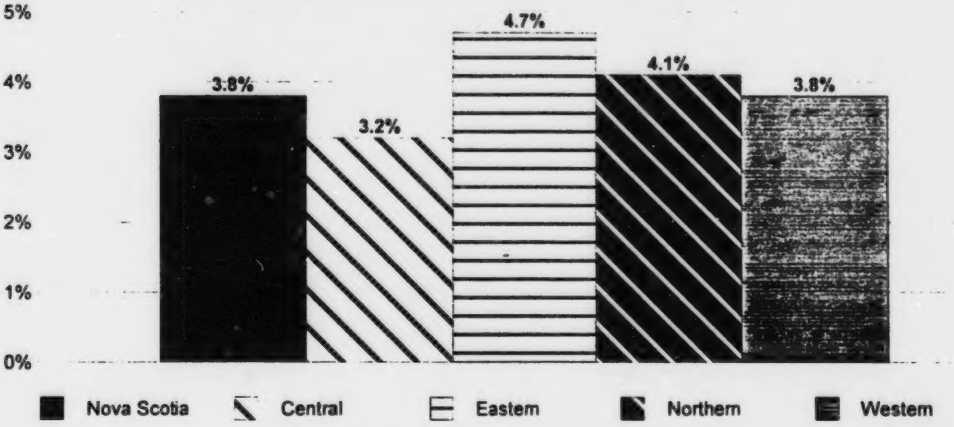
CARDIOVASCULAR SURGERY WAIT TIMES (ELECTIVE)

by Month - April 1997 to March 1998



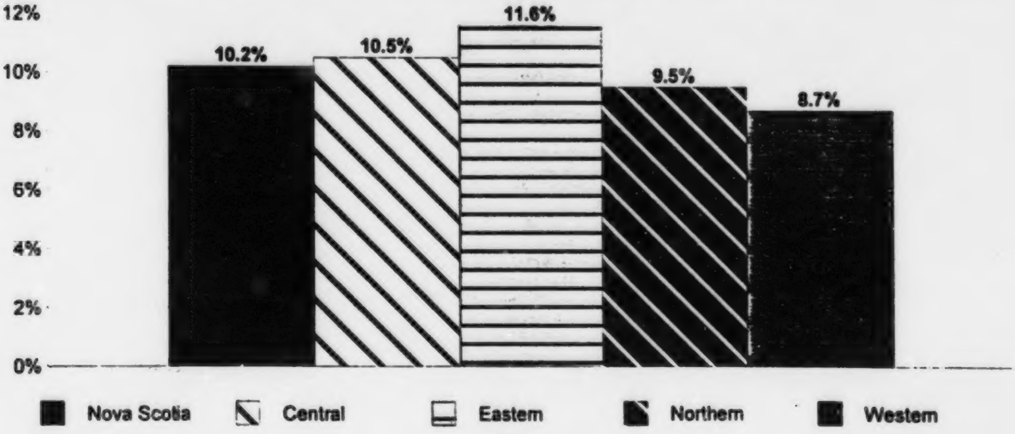
NON-ELECTIVE READMISSIONS TO THE SAME HOSPITAL WITHIN ONE WEEK OF DISCHARGE

By Region of Hospitalization - 1997/98



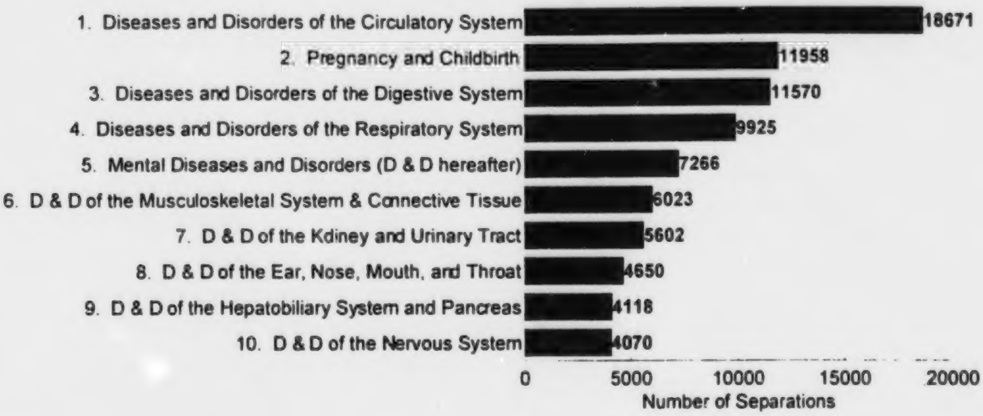
NON-ELECTIVE READMISSIONS TO THE SAME HOSPITAL WITHIN ONE MONTH OF DISCHARGE

By Region of Hospitalization - 1997/98



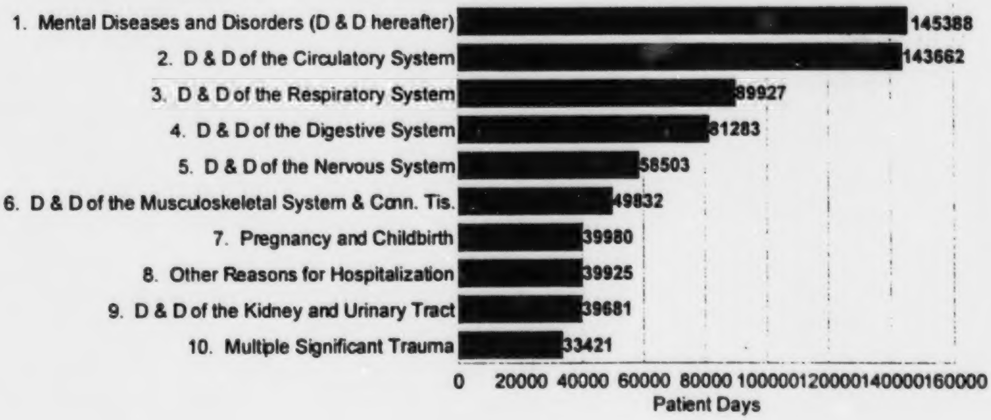
ACUTE CARE 'TOP TEN' CIHI MAJOR CLINICAL CATEGORIES

Nova Scotia - In-Patient Separations Only - 1997/98 - By Region of Hospitalization - Excludes Newborns



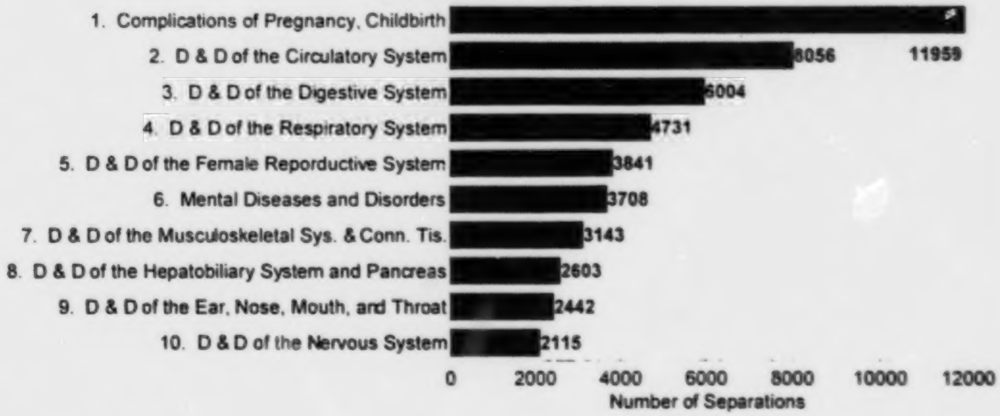
ACUTE CARE 'TOP TEN' CIHI MAJOR CLINICAL CATEGORIES

Nova Scotia - In-Patient, Patient Days Only - 1997/98 - By Region of Hospitalization - Excludes Newborns



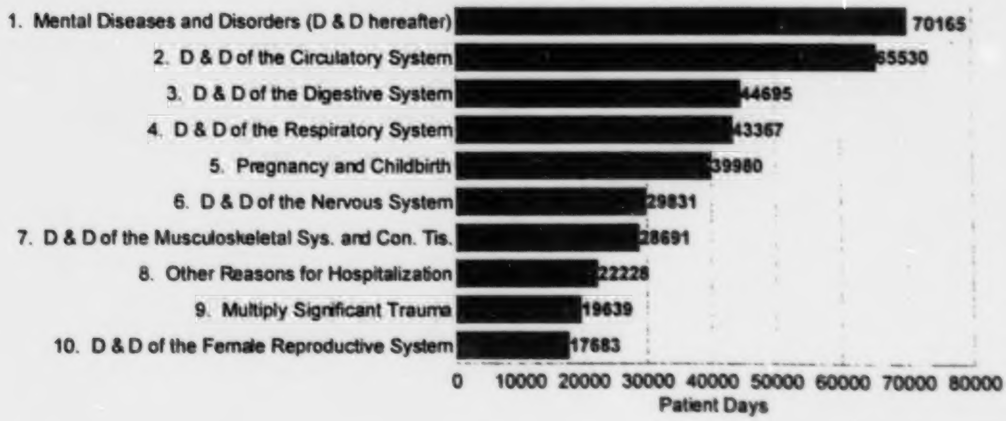
ACUTE CARE 'TOP TEN' CIHI MAJOR CLINICAL CATEGORIES

Nova Scotia - In-Patient Separations Only - 1997/98 - By Region of Hospitalization - Excludes Newborns - Women Only



ACUTE CARE 'TOP TEN' CIHI MAJOR CLINICAL CATEGORIES

Nova Scotia - In-Patient, Patient Days Only - 1997/98 - By Region of Hospitalization - Excludes Newborns - Women Only

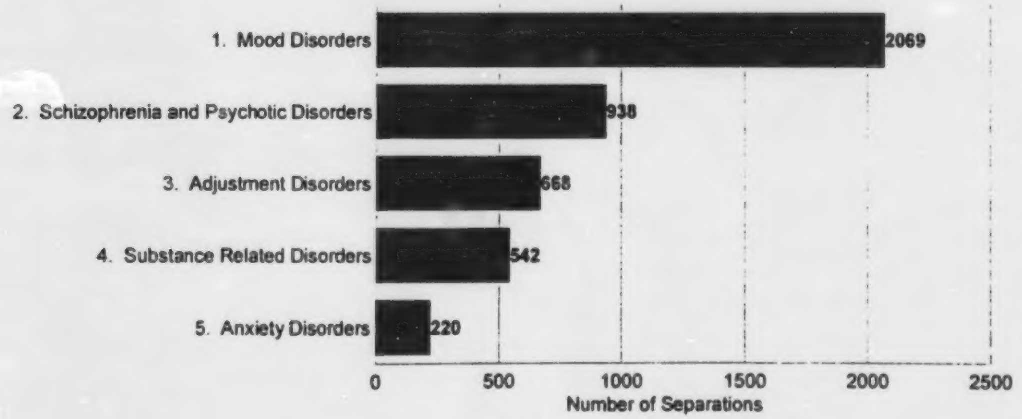


Mental Health

- Top Diagnostic Categories - In-Patients
- Patient Days
- Avearge Length of Stay for Acute and Ambulatory Psychiatric Care
- Top Diagnoses - Outpatient Clinics

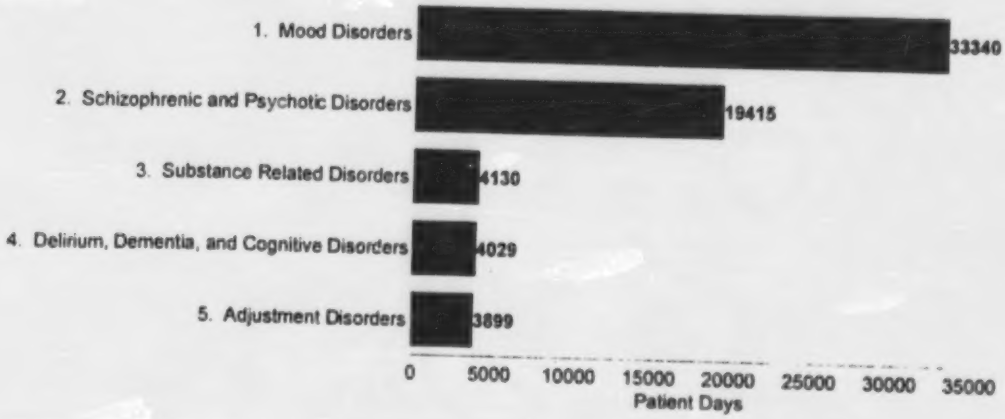
MENTAL HEALTH PROGRAMS

In-Patient Separations - Adults Only (19 Years and Older)
Nova Scotia - Excludes Forensic and Extended Care Units -
1997/98



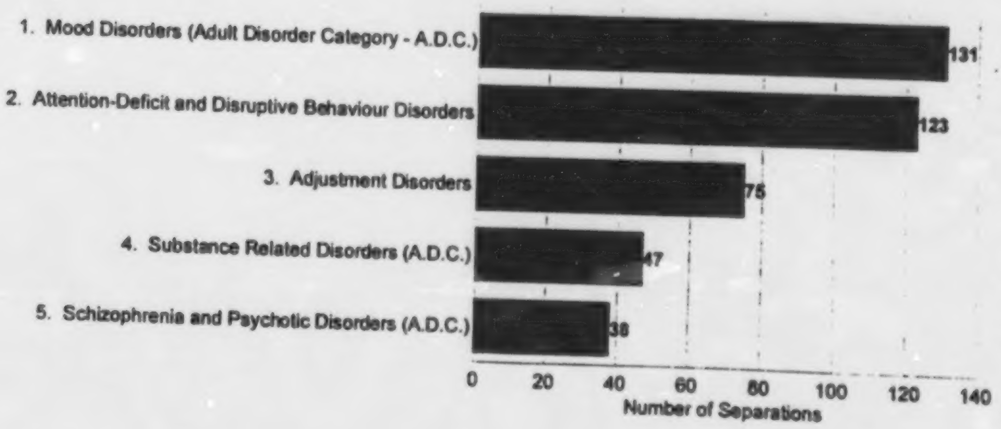
MENTAL HEALTH PROGRAMS

Patient Days - Adults Only (19 Years and Older) Nova Scotia - Excludes Forensic and Extended Care Units - 1997/98



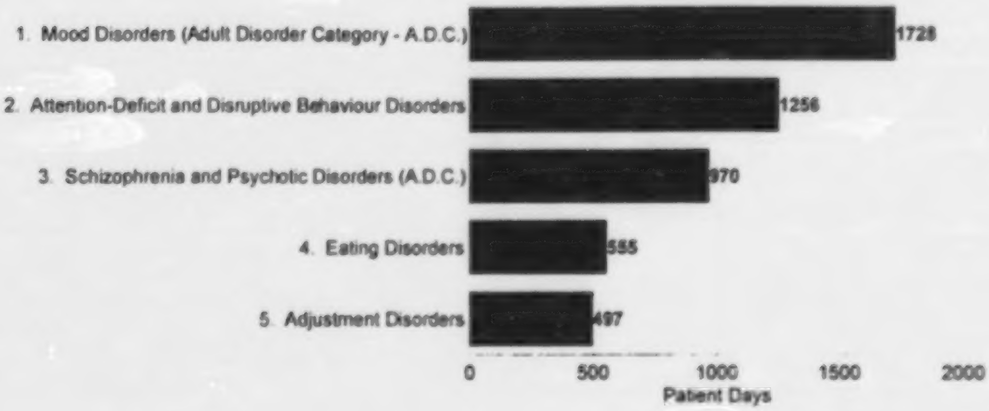
MENTAL HEALTH PROGRAMS

In-Patient Separations - Children Only (18 Years and Younger) - Nova Scotia -Excludes Forensic and Extended Care Units -1997/98



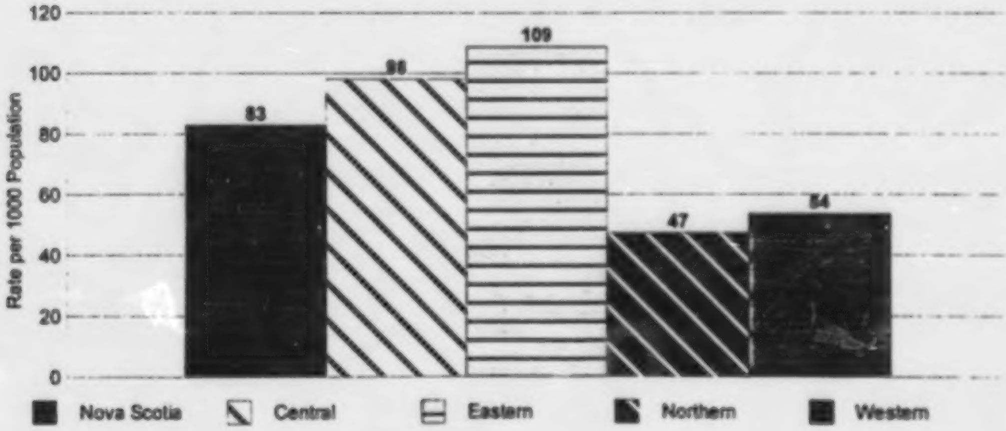
MENTAL HEALTH PROGRAMS

Patient Days - Children Only (18 Years and Younger) - Nova Scotia - Excludes Forensic and Extended Care Units - 1997/98



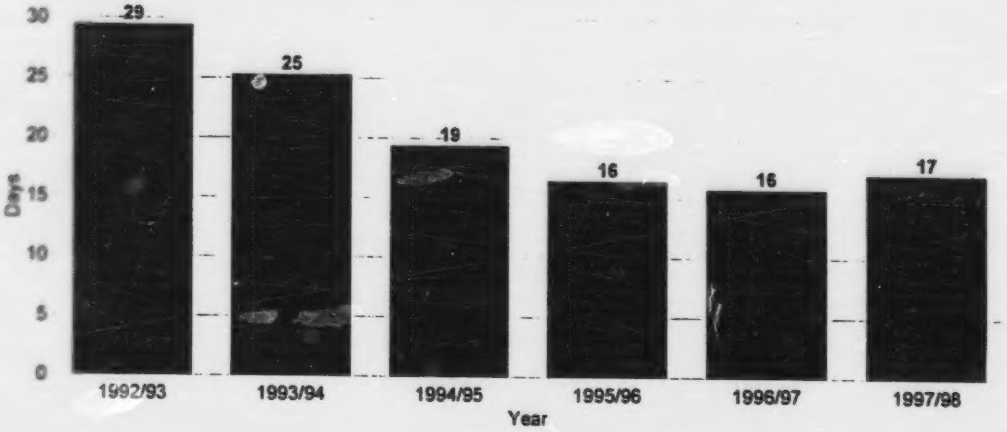
MENTAL HEALTH PROGRAMS PATIENT DAYS PER 1000 POPULATION

Acute Psychiatric Care by Region of Residence
Crude Rates per 1000 Population - 1997/98



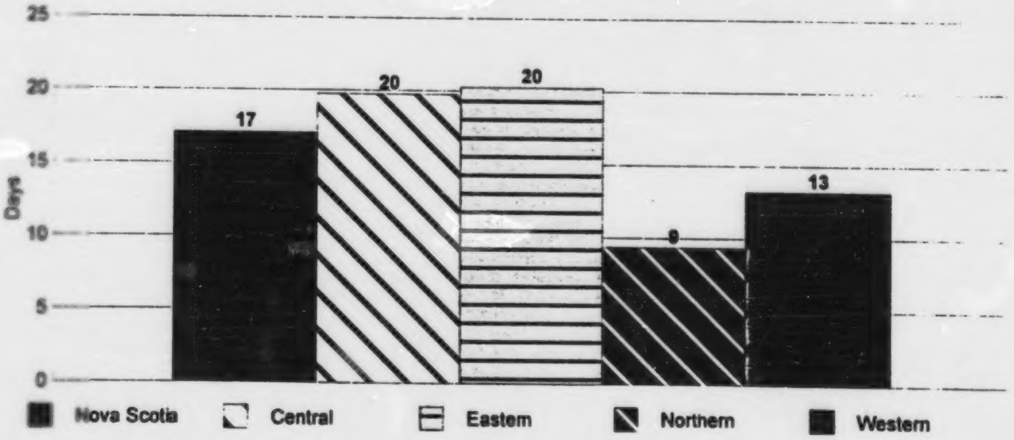
MENTAL HEALTH PROGRAMS AVERAGE LENGTH OF STAY

Acute Psychiatric Care - Adults Only
Nova Scotia - 1992/93 to 1997/98



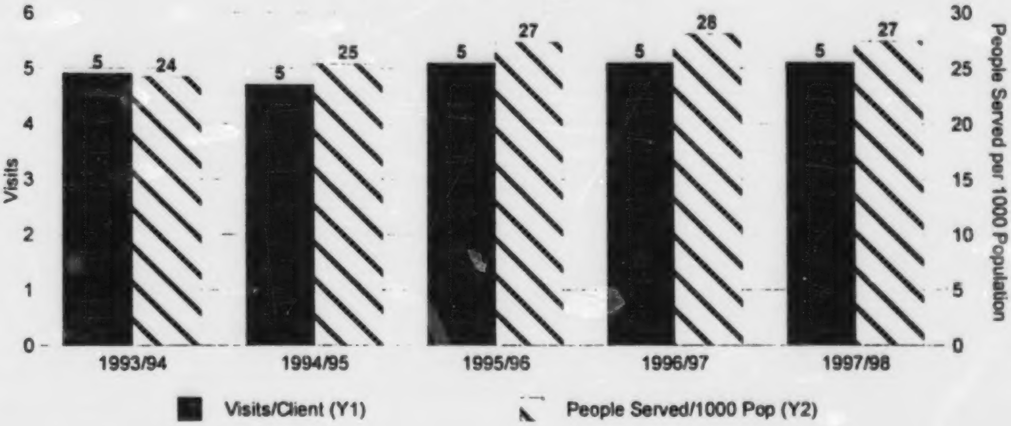
MENTAL HEALTH PROGRAMS AVERAGE LENGTH OF STAY

Acute Psychiatric Care
by Region of Residence - 1997/98



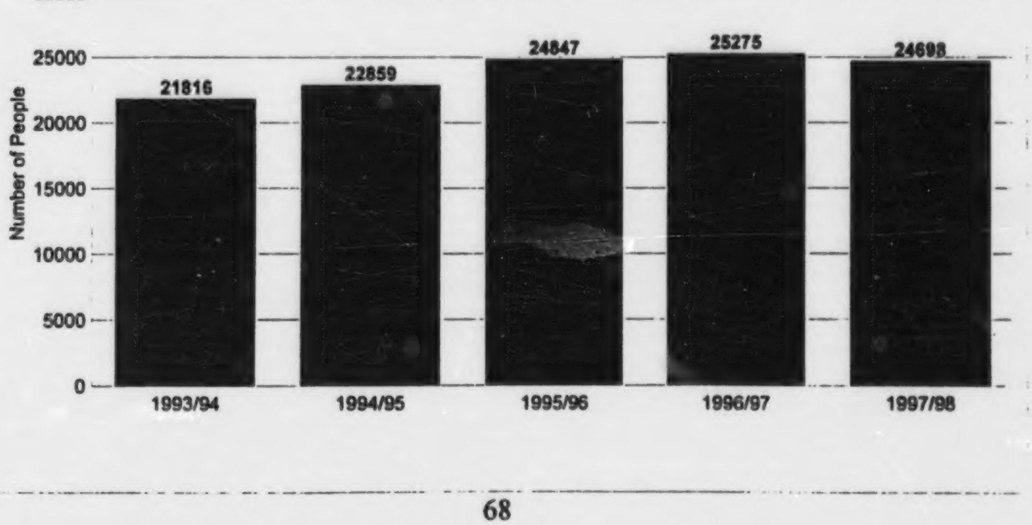
MENTAL HEALTH PROGRAMS AMBULATORY CARE SERVICE LEVELS

Average MIS Visits per Client and Active MIS Clients per 1000 Population Rate



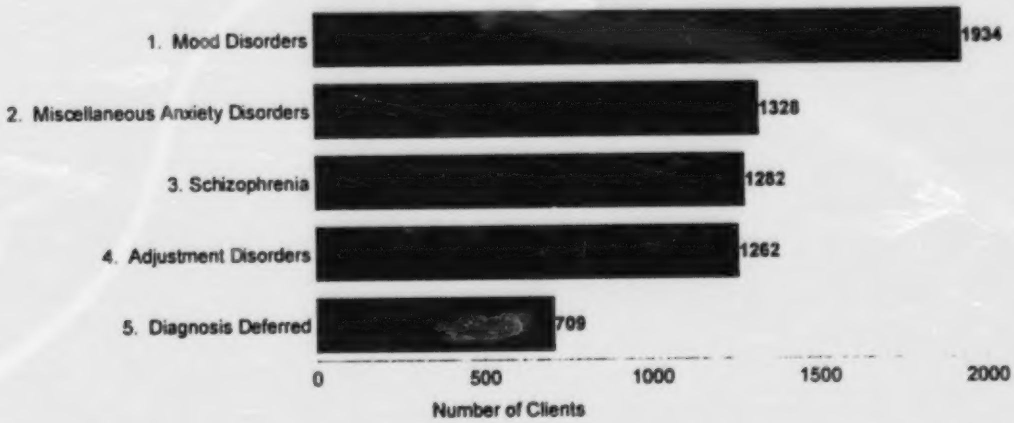
MENTAL HEALTH PROGRAMS AMBULATORY CARE

Number of People Served - Mental Health Outpatient Information System (MHOIS) - Unique Clients - 1993/94 to 1997/98



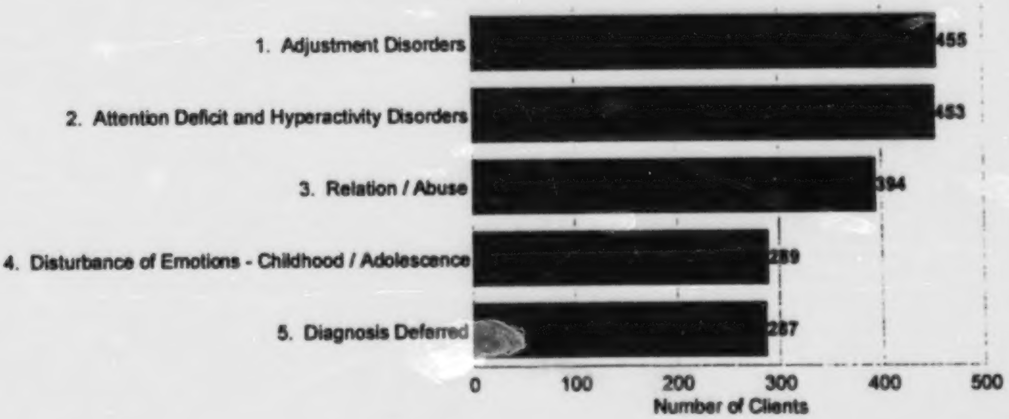
MENTAL HEALTH PROGRAMS TOP DIAGNOSES

Outpatient Clinics (Ambulatory Care) - Adults (19 Years of Age Plus) -1997/98



MENTAL HEALTH PROGRAMS TOP DIAGNOSES

Outpatient Clinics (Ambulatory Care) - Youth (18 Years and Under) 1997/98

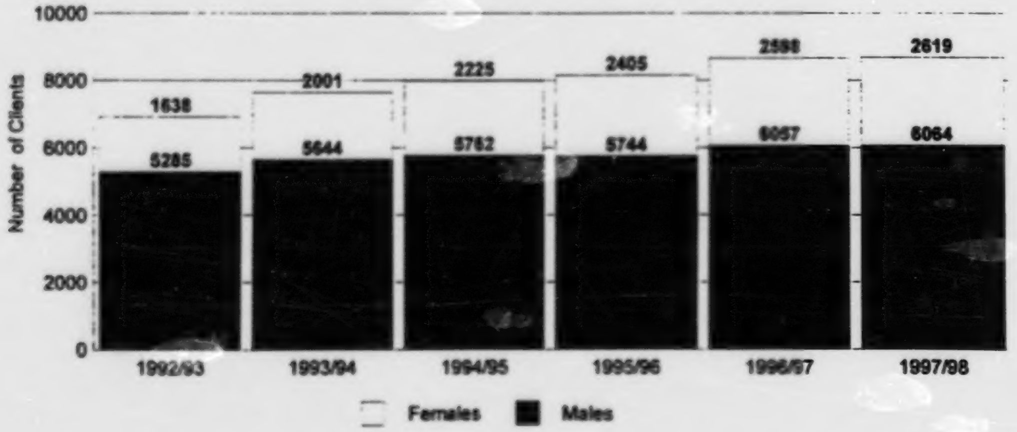


ADDICTION SERVICES PROGRAMS

- Number of Clients Served

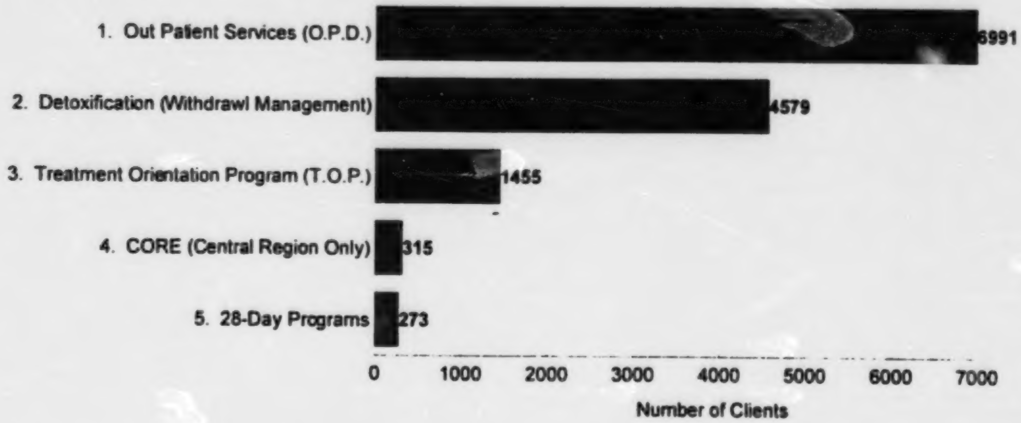
ADDICTION SERVICES PROGRAMS

Number of Clients Served - By Gender



ADDICTION SERVICES PROGRAMS - 1997/98

Service Utilization Breakdown: Outpatient Services and Inpatient Services -Service Available in Each Region - Service Titles Vary Between Regions

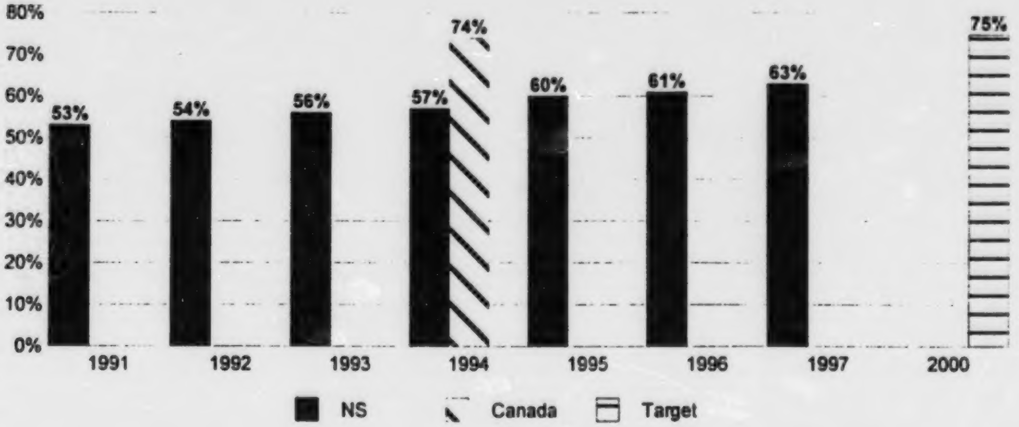


PUBLIC HEALTH

- Breastfeeding Rates
- Influenza Vaccinations
- Sexually Transmitted Diseases
- HIV/AIDS

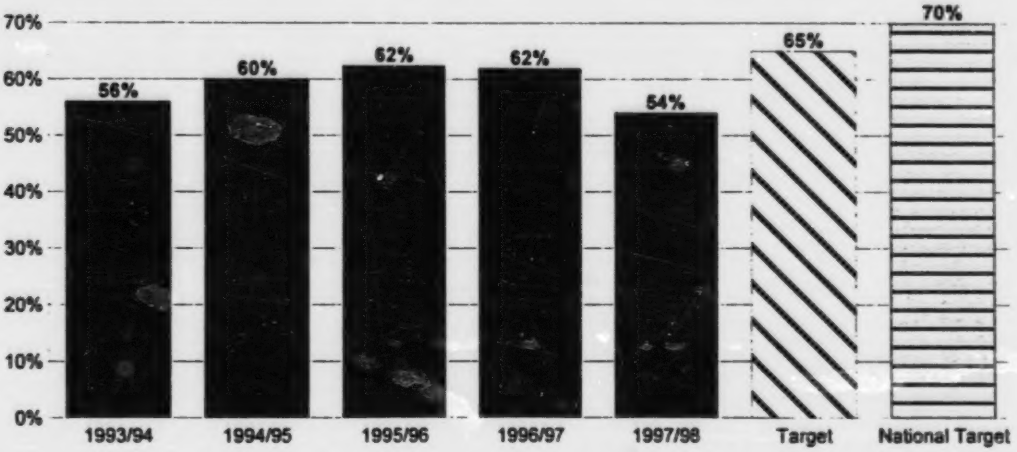
BREAST FEEDING RATES - NOVA SCOTIA - 1988 TO 1997 AND CANADA 1994

The Rate is Based on The Number of Women Breastfeeding at Hospital Discharge



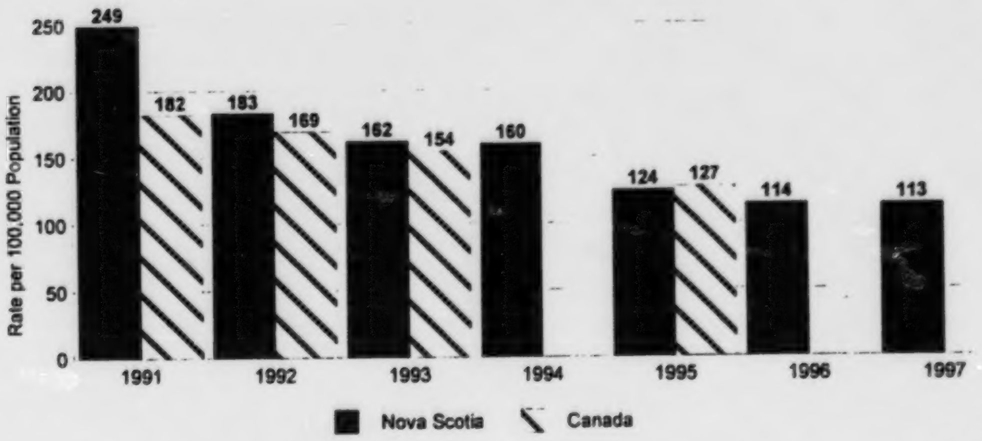
INFLUENZA VACCINATION RATES - NOVA SCOTIA

Percentage of Adults Vaccinated (65 Years of Age Plus)



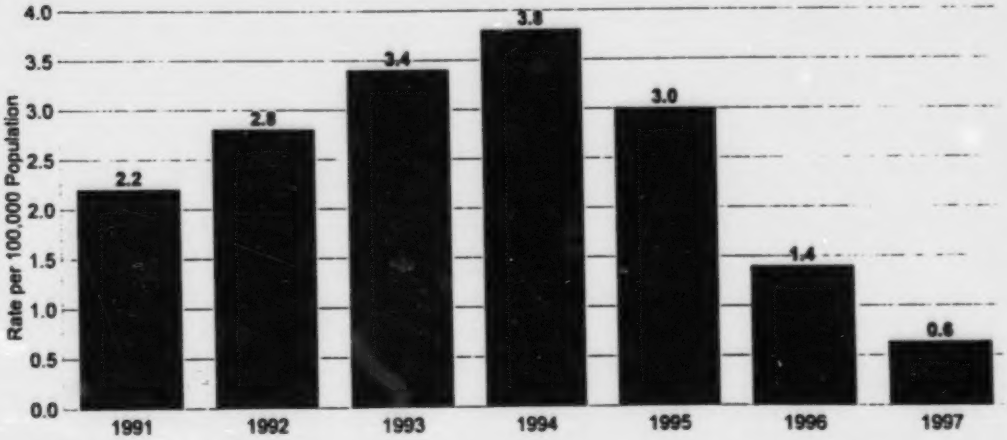
CHLAMYDIA RATES PER 100,000 POPULATION

Nova Scotia - 1991 to 1997; Canada 1991 to 1995



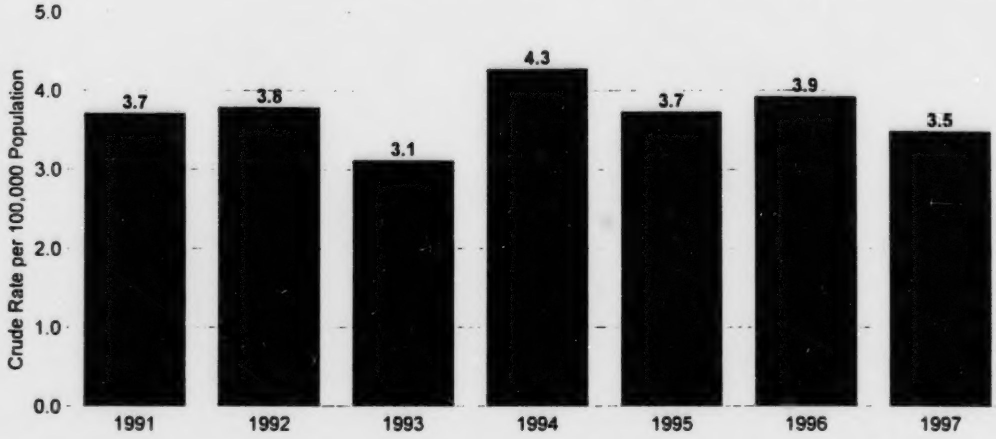
AIDS INCIDENCE PER 100,000 POPULATION

Nova Scotia - 1991 to 1997



CRUDE RATE OF HIV INCIDENCE PER 100,000 POPULATION

Nova Scotia - 1991 to 1997

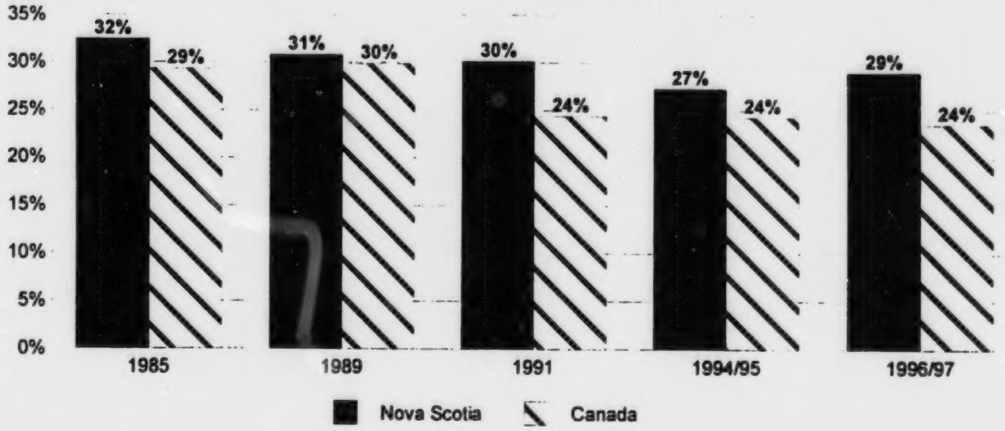


TOBACCO CONTROL UNIT

- Smoking Rates:
  - Adult Smoking Rate
  - Women Who Smoke During Pregnancy
  - Youth Smoking
- Retailer Compliance Rates

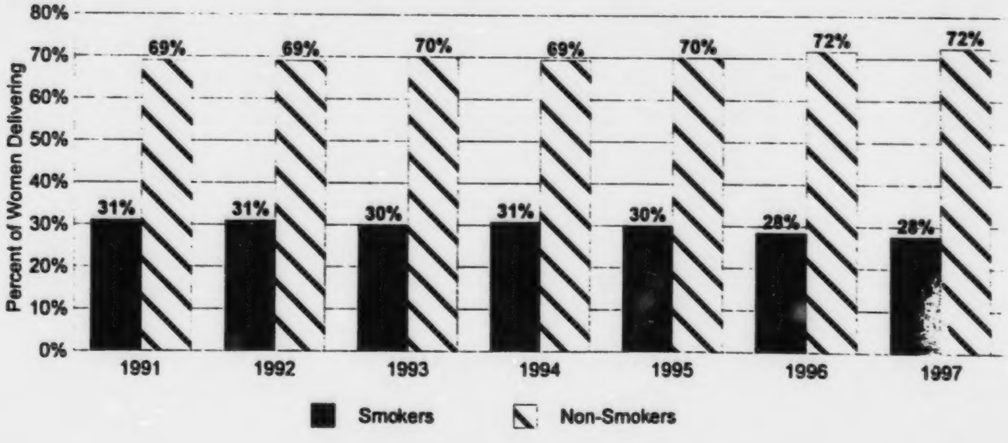
TOBACCO CONTROL UNIT SMOKING RATES

Adults Who Smoke - Nova Scotia and Canada



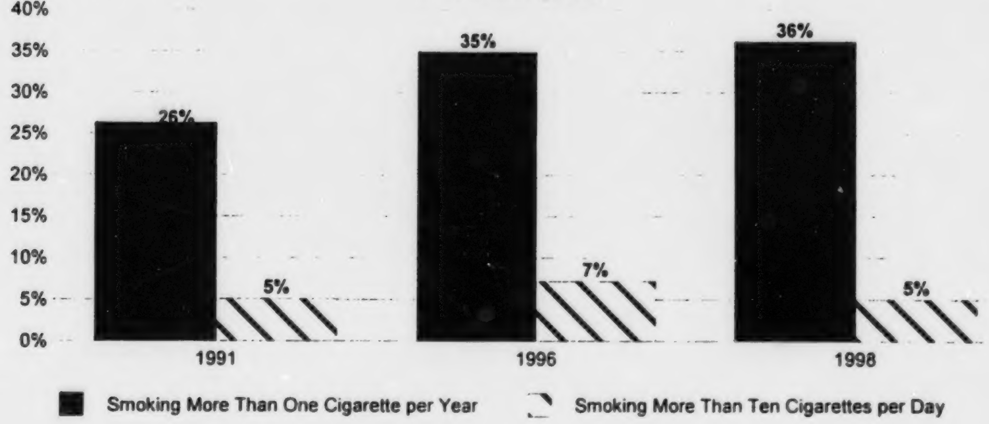
TOBACCO CONTROL UNIT SMOKING RATES

Nova Scotia Women Who Smoke During Pregnancy 1991 to 1997 - Women Who Reported Smoking During Pregnancy at Hospital Discharge



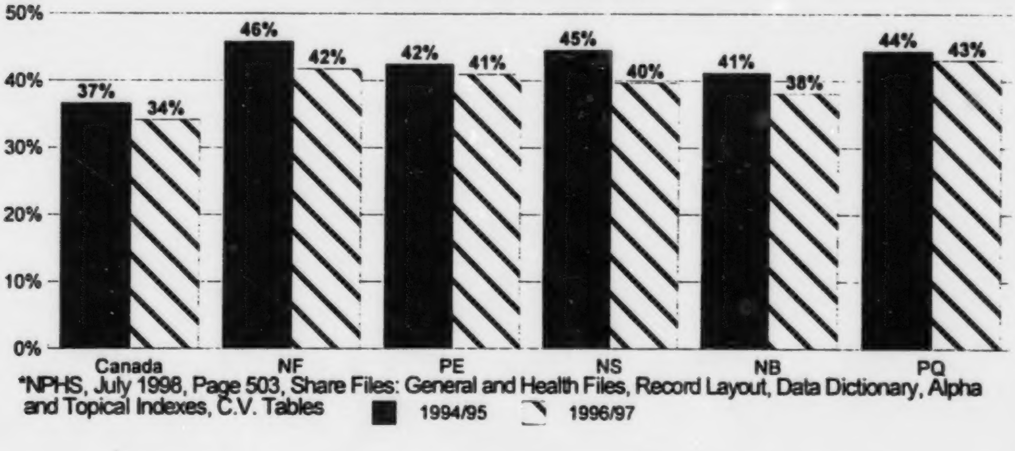
TOBACCO CONTROL UNIT SMOKING RATES

Nova Scotia Youth Smoking - Among Grade 7, 9, 10, and 12 Students - for 1991, 1996, and 1998 - by Cigarette Consumption



ENVIRONMENTAL TOBACCO SMOKE RATES

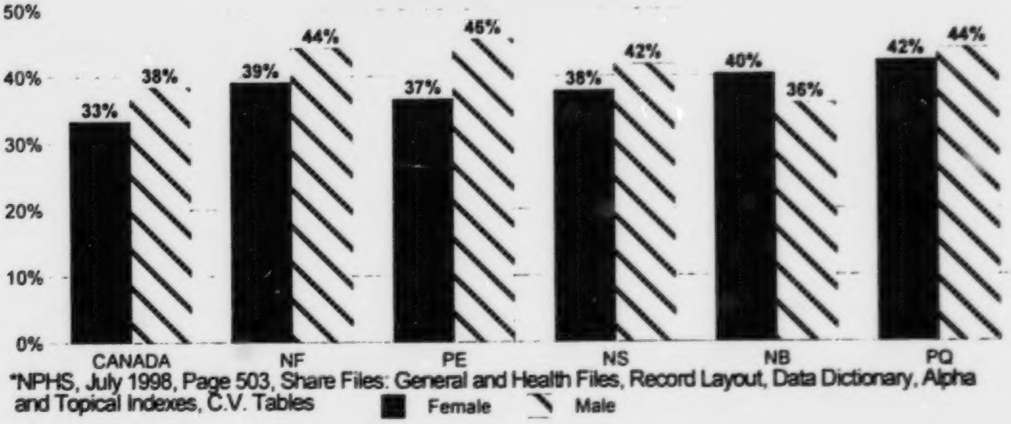
Environmental Tobacco Smoke (ETS) - Those Who Answered 'Yes' to "Does Anyone in this Household Smoke Regularly Inside the House?"* - (12 to 80+ Years of Age) - 1994/95 and 1996/97



*NPHS, July 1998, Page 503, Share Files: General and Health Files, Record Layout, Data Dictionary, Alpha and Topical Indexes, C.V. Tables

ENVIRONMENTAL TOBACCO SMOKE RATES

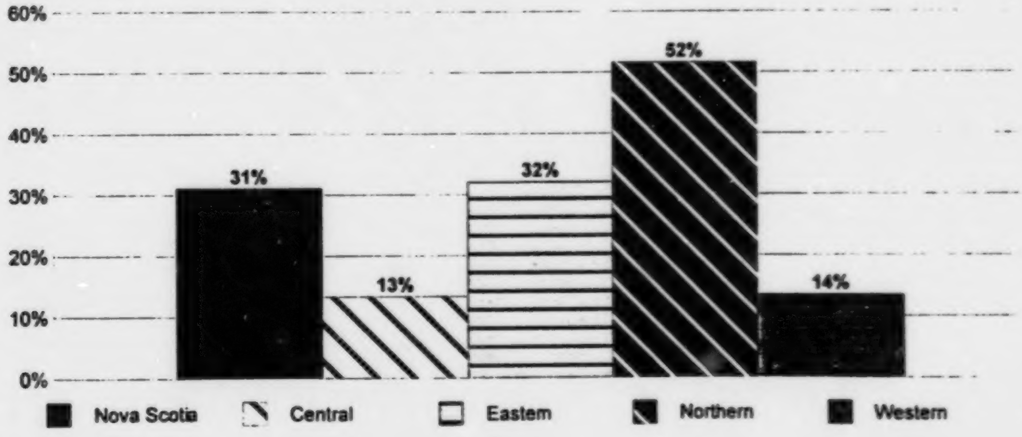
Environmental Tobacco Smoke (ETS) - Those Who Answered 'Yes' to "Does Anyone in this Household Smoke Regularly Inside the House?"* - (12 to 80+ Years of Age) - by Gender -1996/97



*NPHS, July 1998, Page 503, Share Files: General and Health Files, Record Layout, Data Dictionary, Alpha and Topical Indexes, C.V. Tables

TOBACCO CONTROL UNIT COMPLIANCE RATES BY REGION NOVA SCOTIA RETAILERS

1997/98

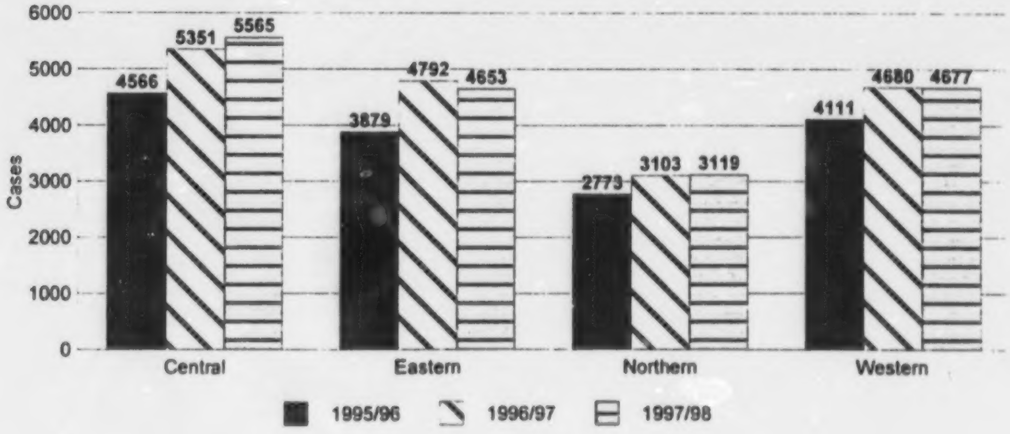


HOME CARE NOVA SCOTIA

- Caseload
- Admissions
  - Total
  - Chronic Home Care
  - Acute Home Care
- Home Oxygen

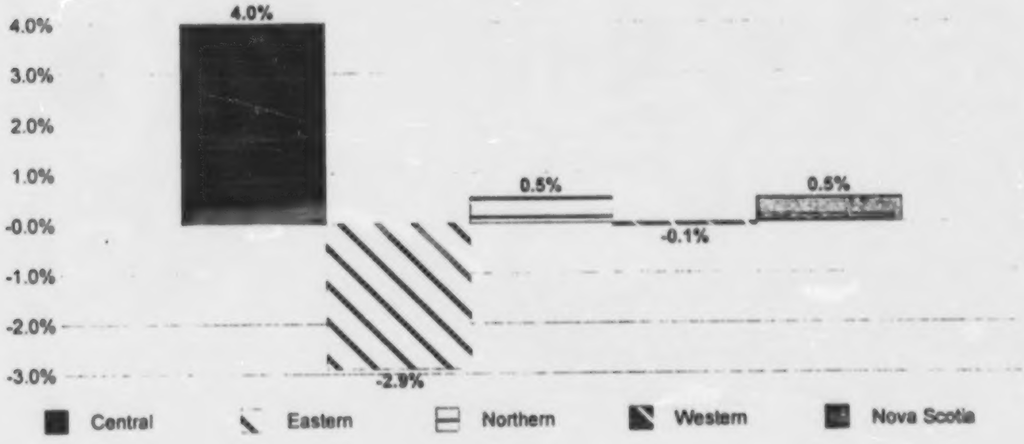
HOME CARE NOVA SCOTIA ACCUMULATED ANNUAL CASELOAD

1995/96 to 1997/98



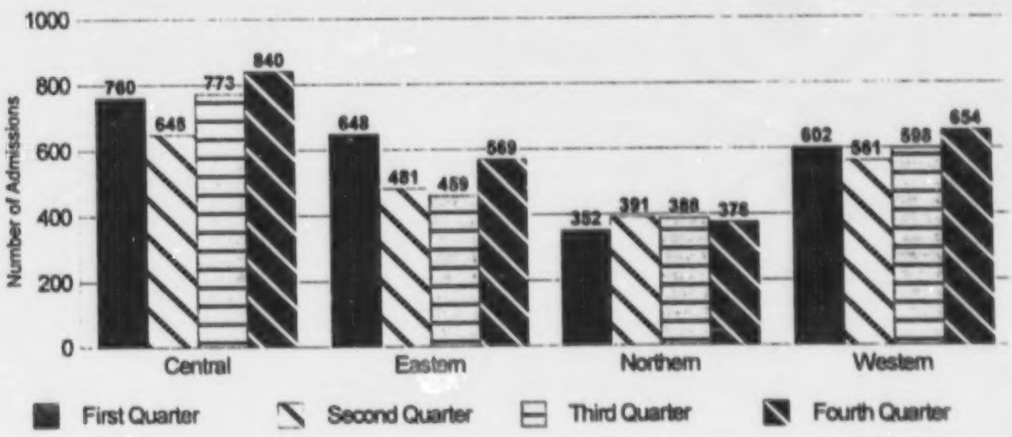
HOME CARE NOVA SCOTIA - NET PERCENTAGE CHANGE IN CASELOAD SINCE APRIL 1997

By Region



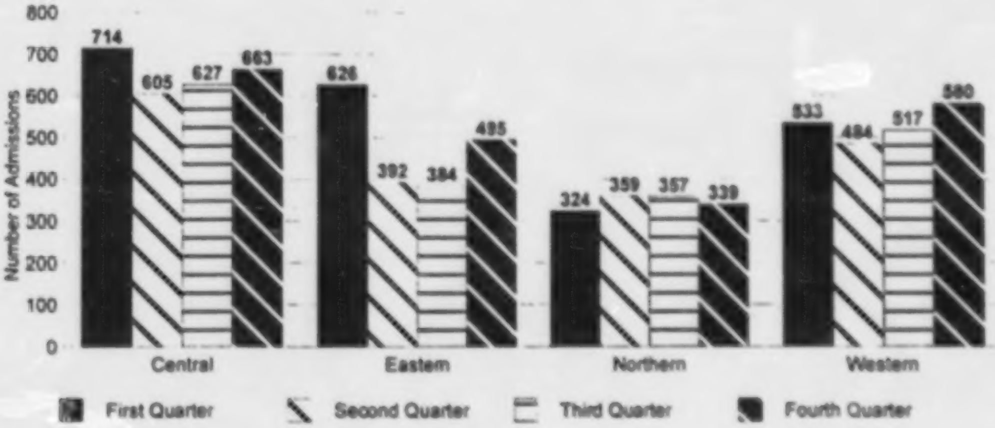
HOME CARE NOVA SCOTIA - 1997/98

Number of Admissions by Quarter



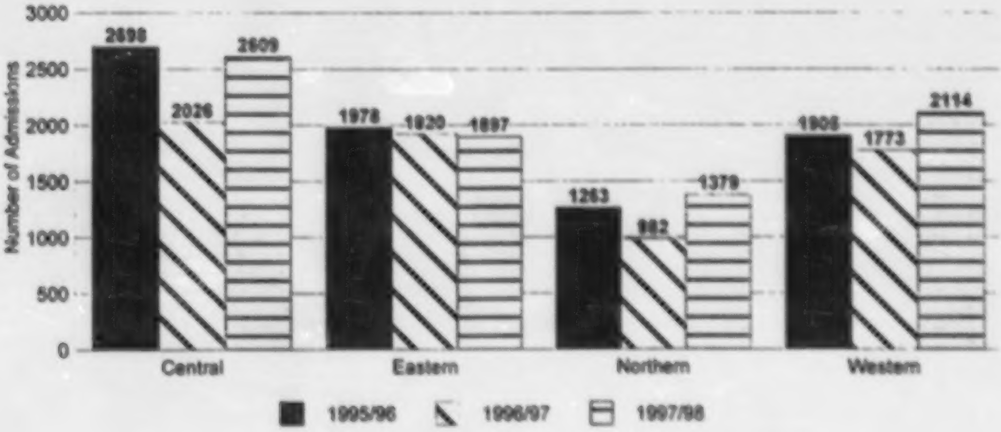
HOME CARE NOVA SCOTIA - 1997/98

Chronic Home Care Services Admissions - by Quarter



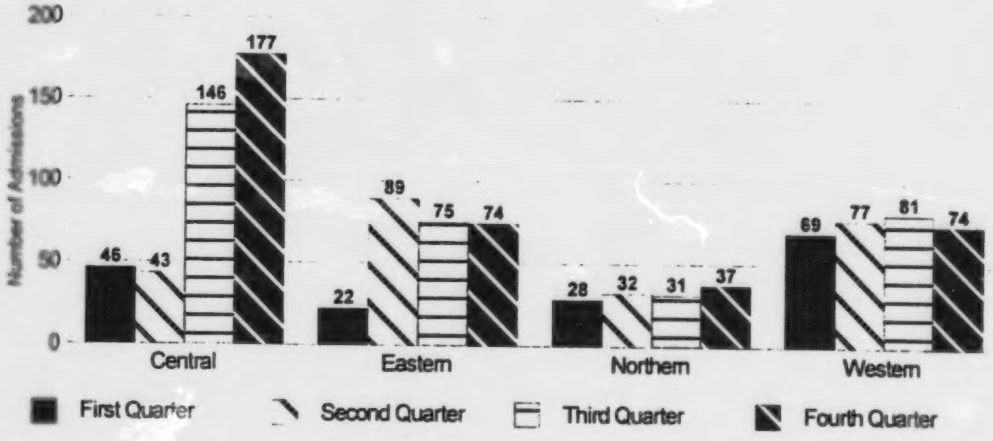
HOME CARE NOVA SCOTIA - 1995/96 TO 1997/98

Chronic Home Care Services Admissions - by Region



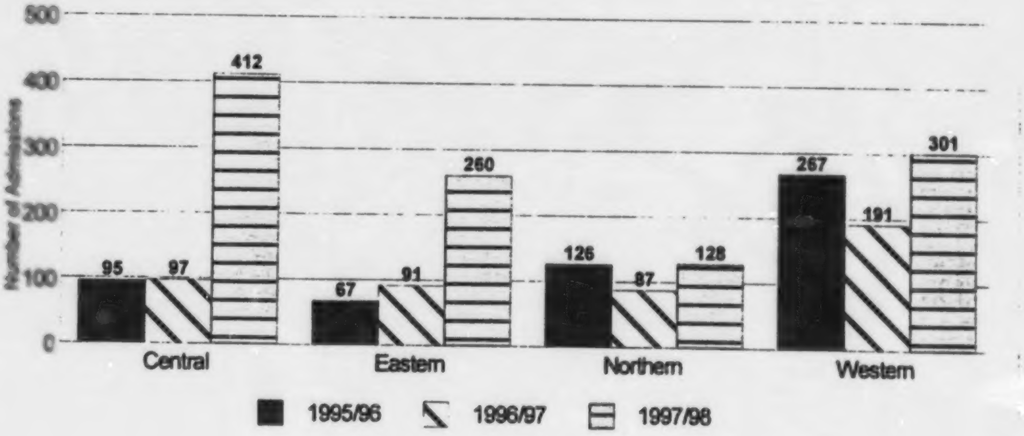
HOME CARE NOVA SCOTIA - 1997/98

Acute Home Care Services Admissions - by Quarter



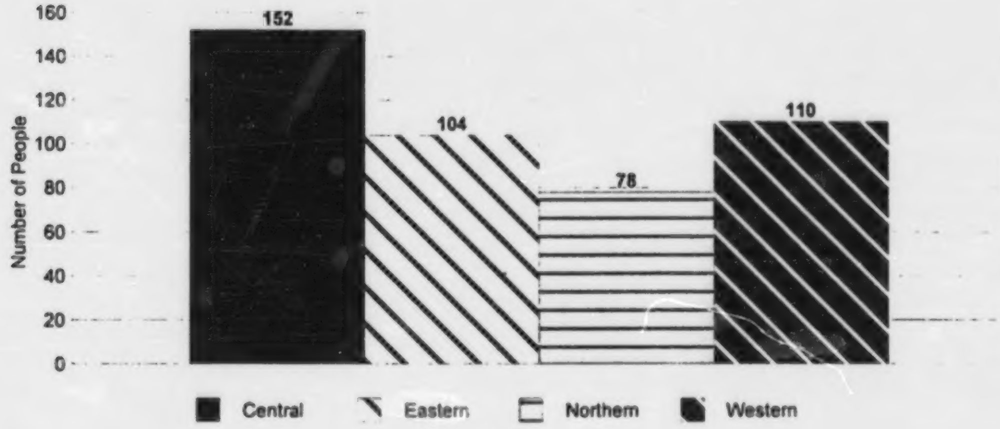
HOME CARE NOVA SCOTIA - 1995/96 TO 1997/98

Acute Home Care Services Admissions - by Region



HOME CARE NOVA SCOTIA
1997/98

Number of Clients Receiving Home Oxygen

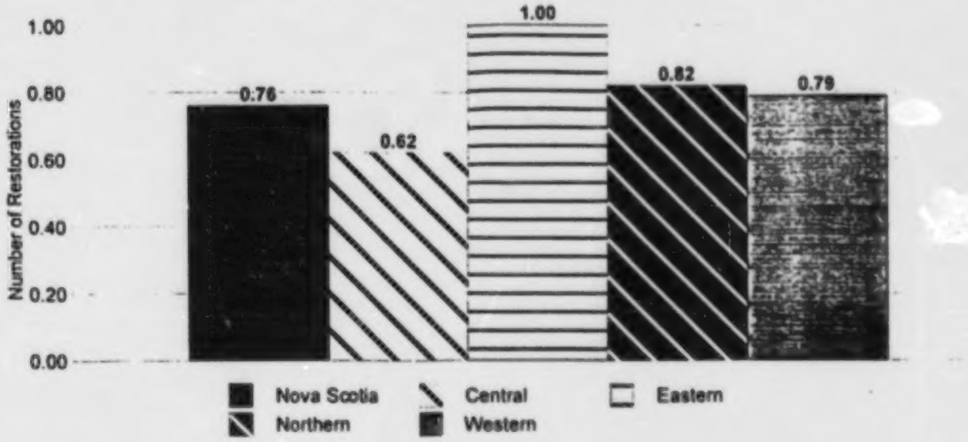


EMERGENCY HEALTH SERVICES

- Government Subsidized Patient Transfers
- Emergency Call and Response Times
- Transports
- ‘Top Ten’ Chief Complaints
- Survival for Out-of-Hospital Cardiac Arrests

DENTICARE - AVERAGE NUMBER OF DENTAL RESTORATIONS PER INSURED

3 to 9 Years of Age - by Region of Residence

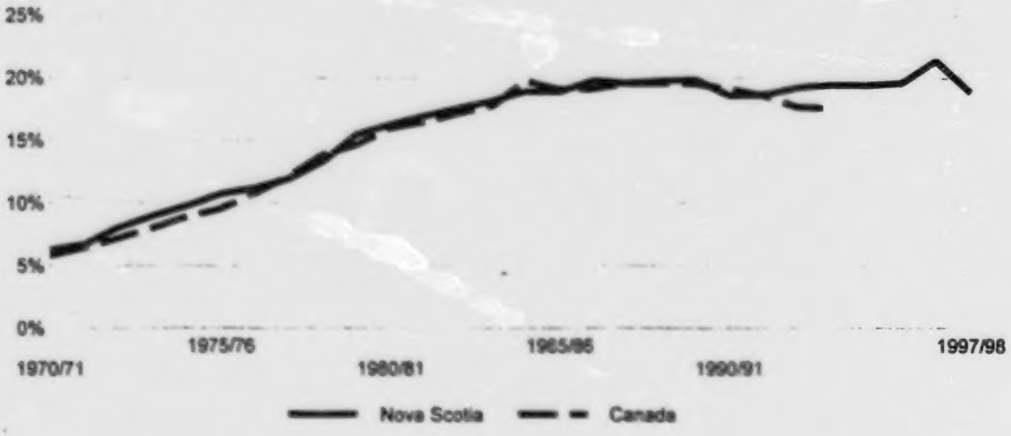


WOMEN'S HEALTH

- Caesarean Sections
- Mammography
- Breast Cancer Mortality Rates
- Gynaecological Cancer Screening
- Cervical Cancer Incidence and Mortality Rates

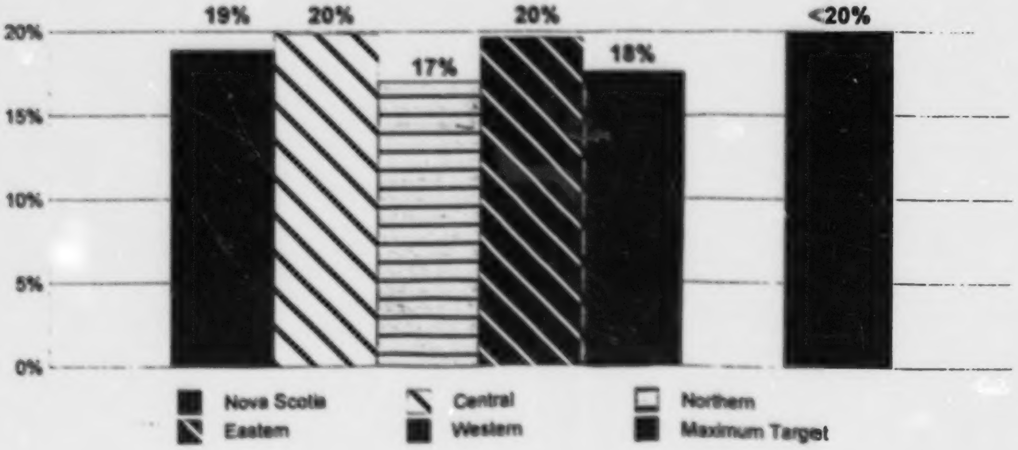
CAESAREAN SECTIONS PER 100 DELIVERIES

Nova Scotia and Canada 1970/71 to 1997/98



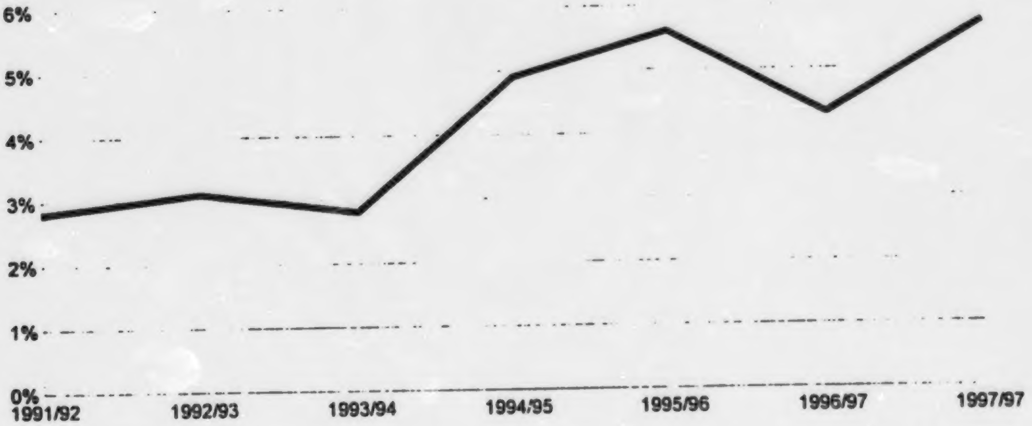
CAESAREAN SECTION RATE

By Region of Hospitalization - Nova Scotia
1997/98



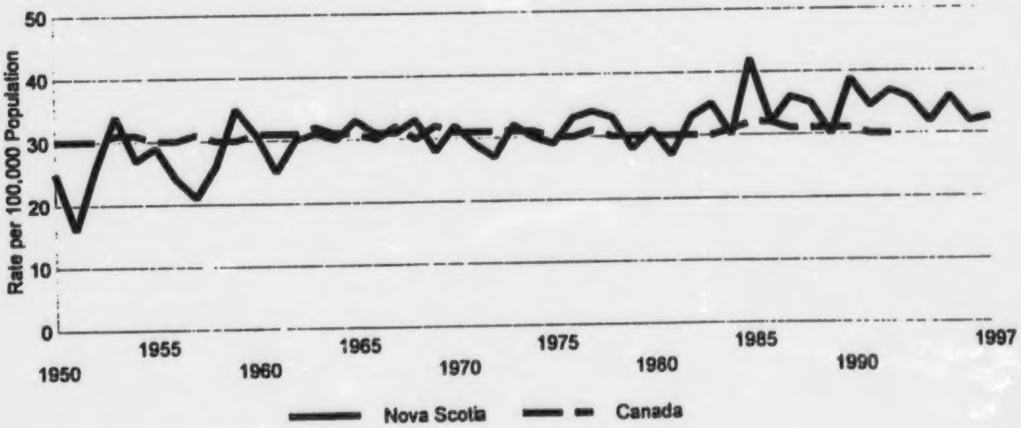
MAMMOGRAPHY SCREENING PROVINCE - WIDE RATE

Percentage of Women Screened - (Aged 50 to 69 Years)
1991/92-1997/98



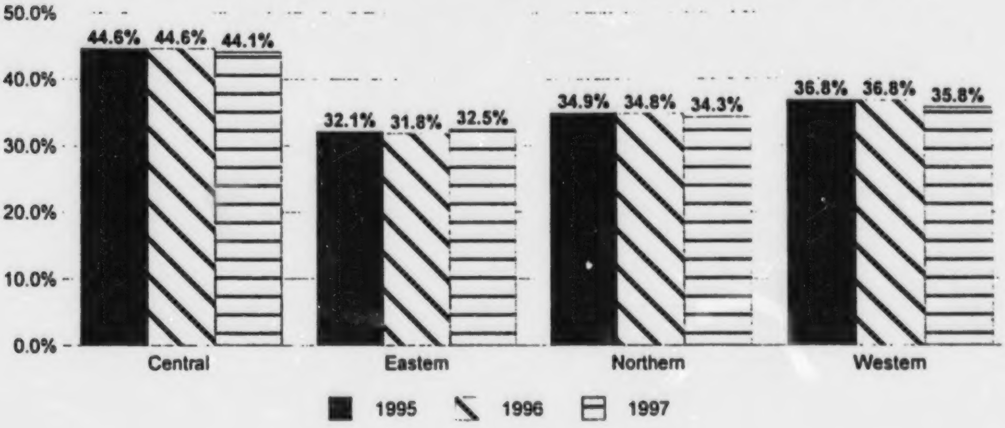
BREAST CANCER MORTALITY RATES

Nova Scotia and Canada - 1950 to 1997 - Age-Standardized Rates per 100,000 of the Female Population



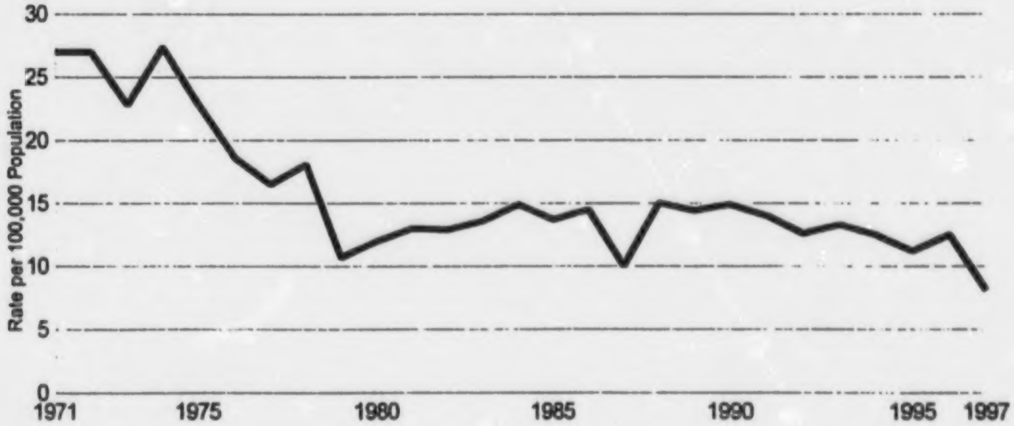
NOVA SCOTIA GYNAECOLOGICAL CANCER SCREENING PROGRAM

Percentage of Women Screened - PAP Test - (15 Plus Years of Age) - 1995 to 1997 by Region of Residence



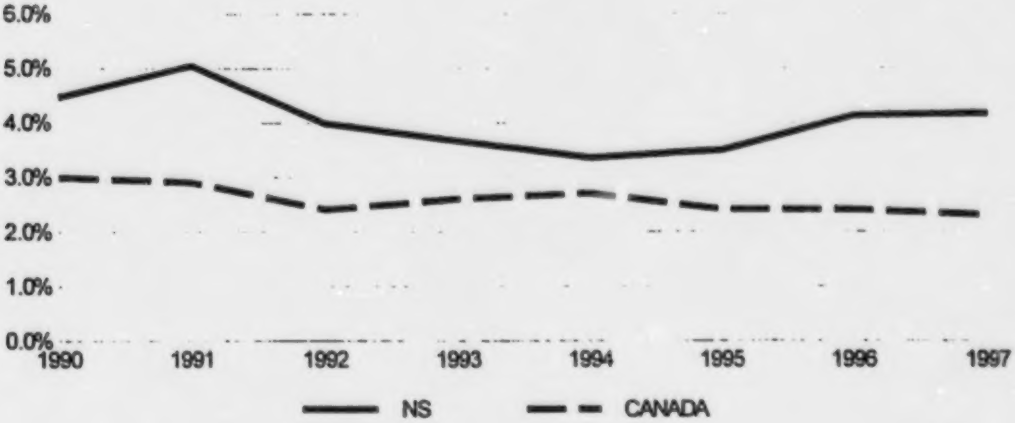
CERVICAL CANCER INCIDENCE RATES

NOVA SCOTIA - 1971 to 1997



CERVICAL CANCER MORTALITY RATES

Nova Scotia and Canada - 1990 to 1997

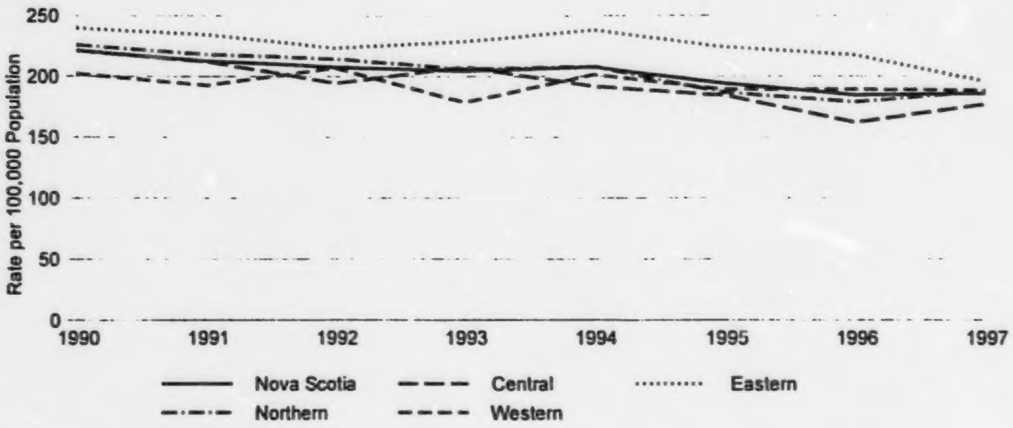


MORTALITY IN NOVA SCOTIA

- Heart and Respiratory Diseases
- Malignant Neoplasms
- Accidents and Adverse Effects
- All Cause Mortality

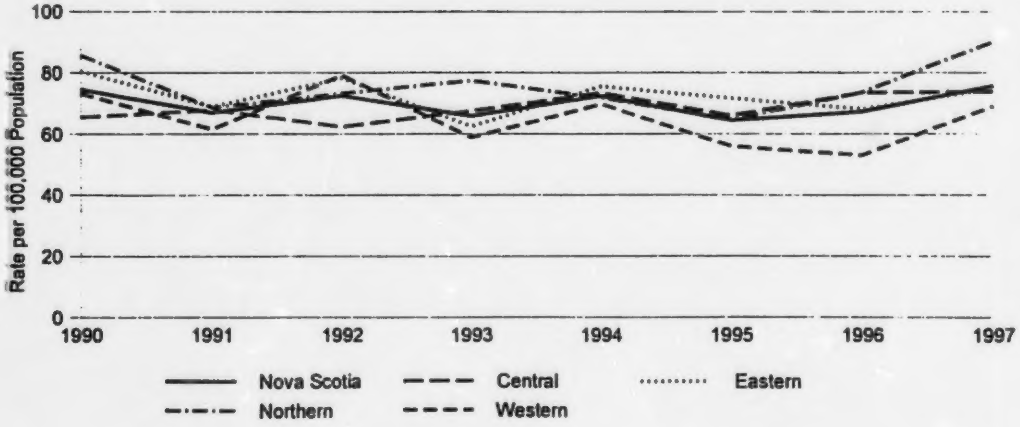
HEART DISEASE

Nova Scotia - by Region of Residence - Age and Sex
Standardized Mortality Rate per 100,000 Population



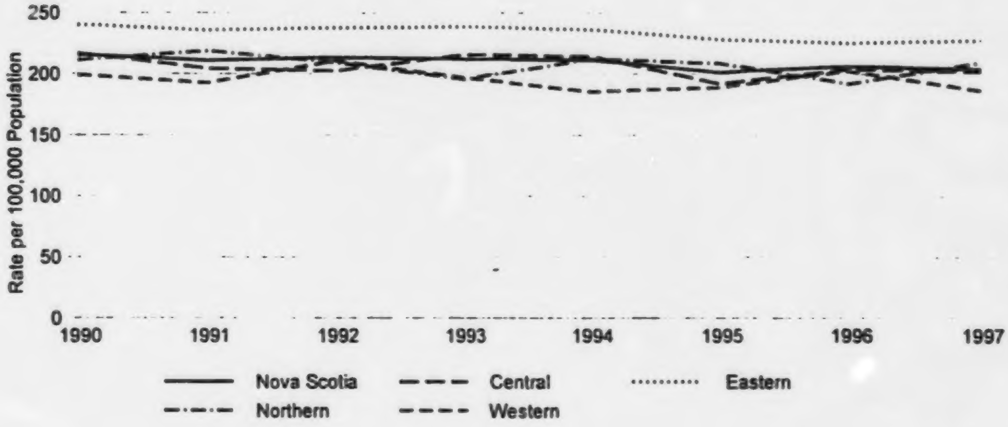
RESPIRATORY DISEASES

Nova Scotia - by Region of Residence - Age and Sex
Standardized Mortality Rate per 100,000 Population



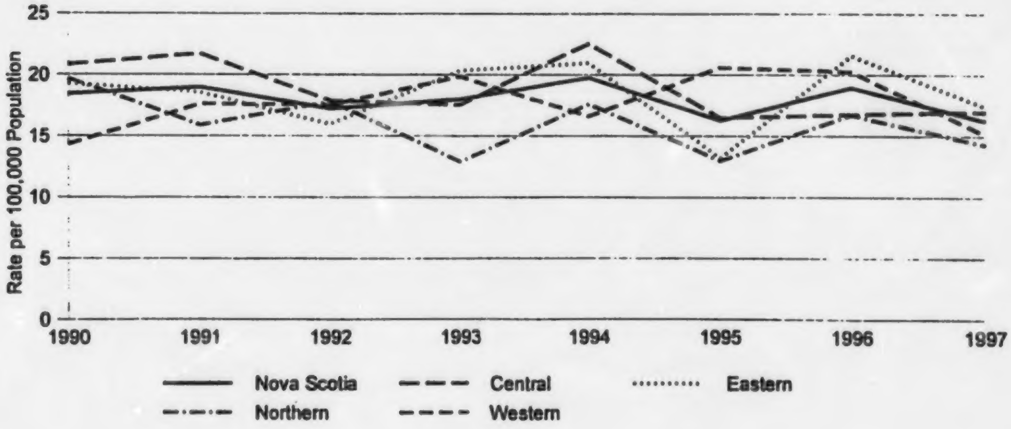
ALL MALIGNANT NEOPLASMS

Nova Scotia - by Region of Residence - Age and Sex Standardized Mortality Rate per 100,000 Population



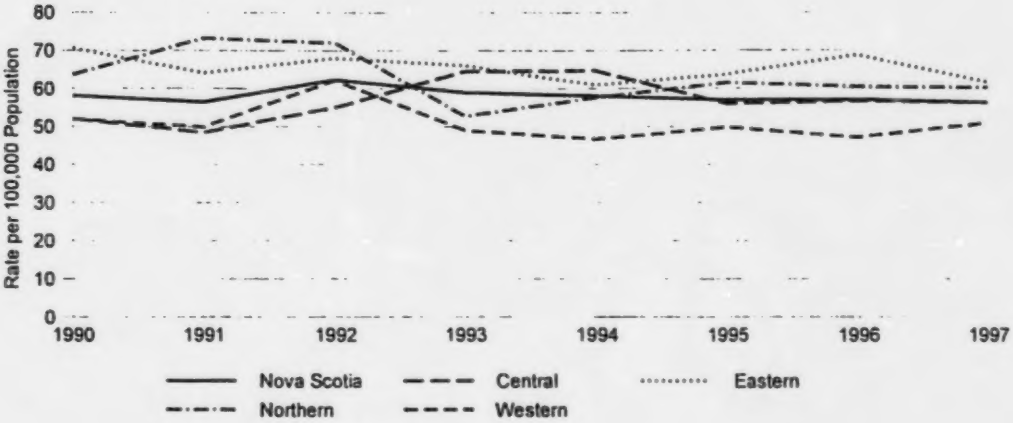
COLORECTAL CANCER

Nova Scotia - by Region of Residence - Age and Sex Standardized Mortality Rate per 100,000 Population



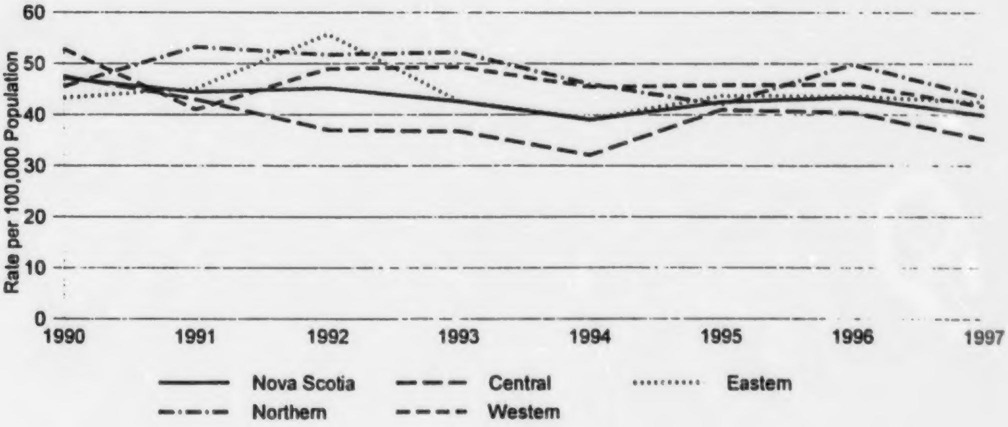
LUNG CANCER (INCLUDING TRACHAE AND BRONCHUS)

Nova Scotia - by Region of Residence - Age and Sex Standardized Mortality Rate per 100,000 Population



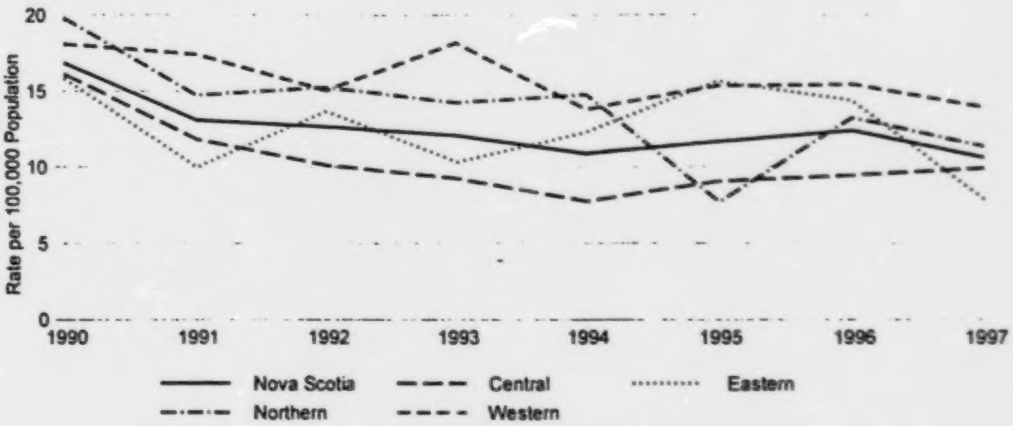
ALL ACCIDENTS, INJURIES, AND POISONINGS

Nova Scotia - by Region of Residence - Age and Sex Standardized Mortality Rate per 100,000 Population



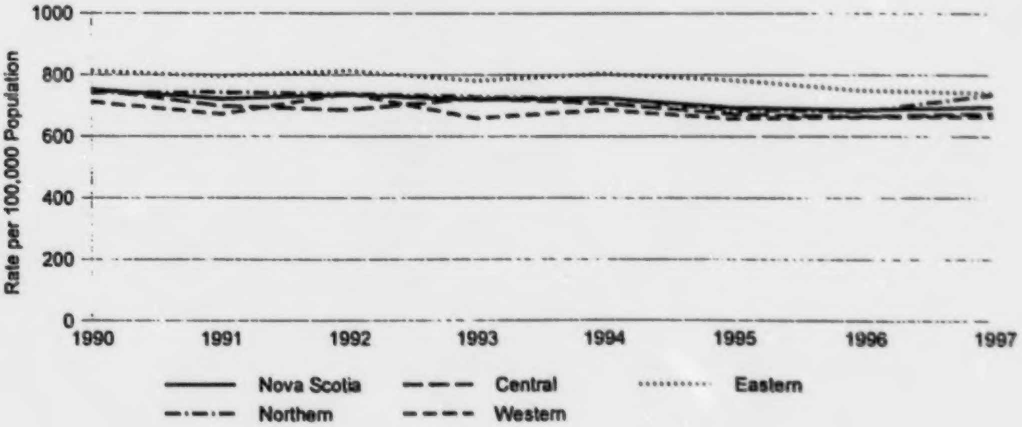
ALL TRAUMATIC ACCIDENTAL CAUSES

Nova Scotia - by Region of Residence - Age and Sex Standardized Mortality Rate per 100,000 Population



ALL CAUSE MORTALITY

Nova Scotia - by Region of Residence - Age and Sex Standardized Mortality Rate per 100,000 Population

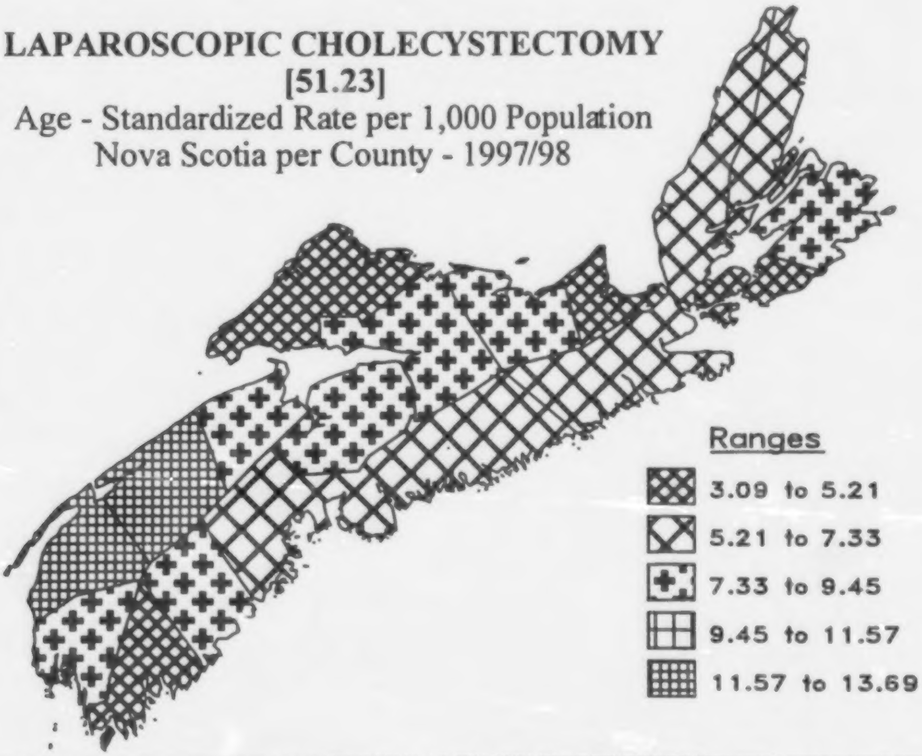


PROCEDURE RATE VARIATION

County of Residence Level Analysis

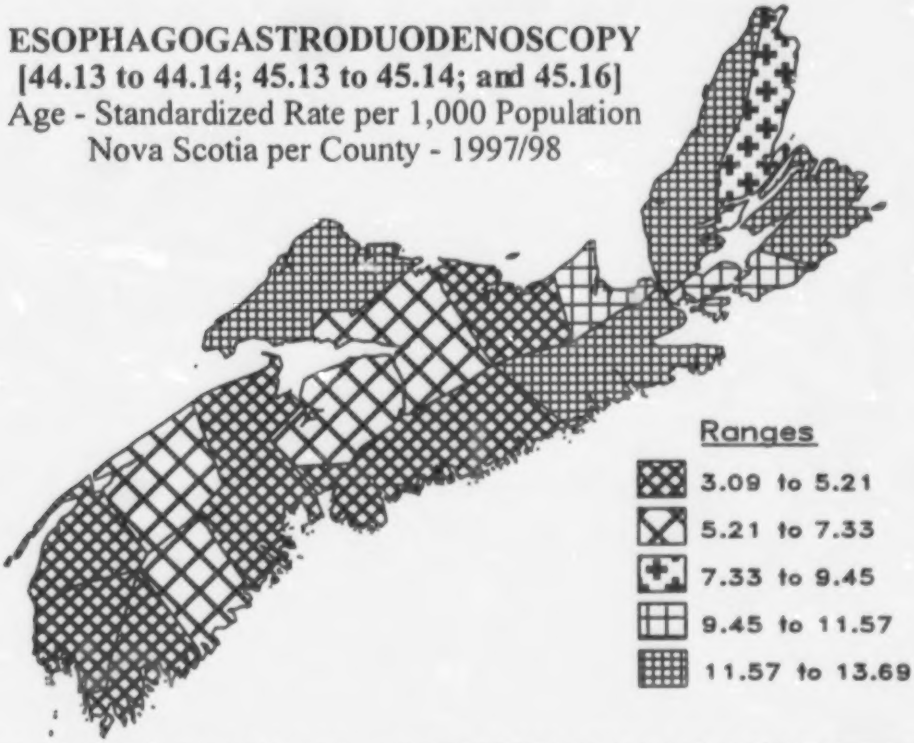
- Selected Individual Procedures
  - Laparoscopic Cholecystectomy, Esophagogastroduodenoscopy, Bilateral Myringotomy and Tubes, Colonoscopy
- Selected Procedure Groups
  - Cholecystectomy (All techniques), Cataract Extraction, Coronary Artery Bypass Grafting, Hysterectomy (All techniques)

LAPAROSCOPIC CHOLECYSTECTOMY
[51.23]
Age - Standardized Rate per 1,000 Population
Nova Scotia per County - 1997/98



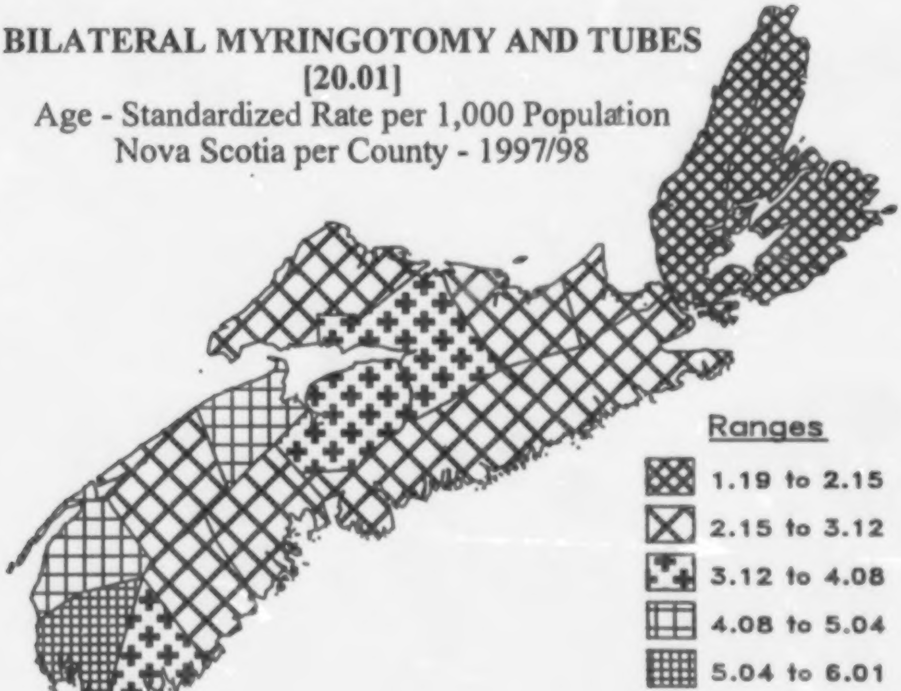
ESOPHAGOGASTRODUODENOSCOPY
[44.13 to 44.14; 45.13 to 45.14; and 45.16]

Age - Standardized Rate per 1,000 Population
Nova Scotia per County - 1997/98

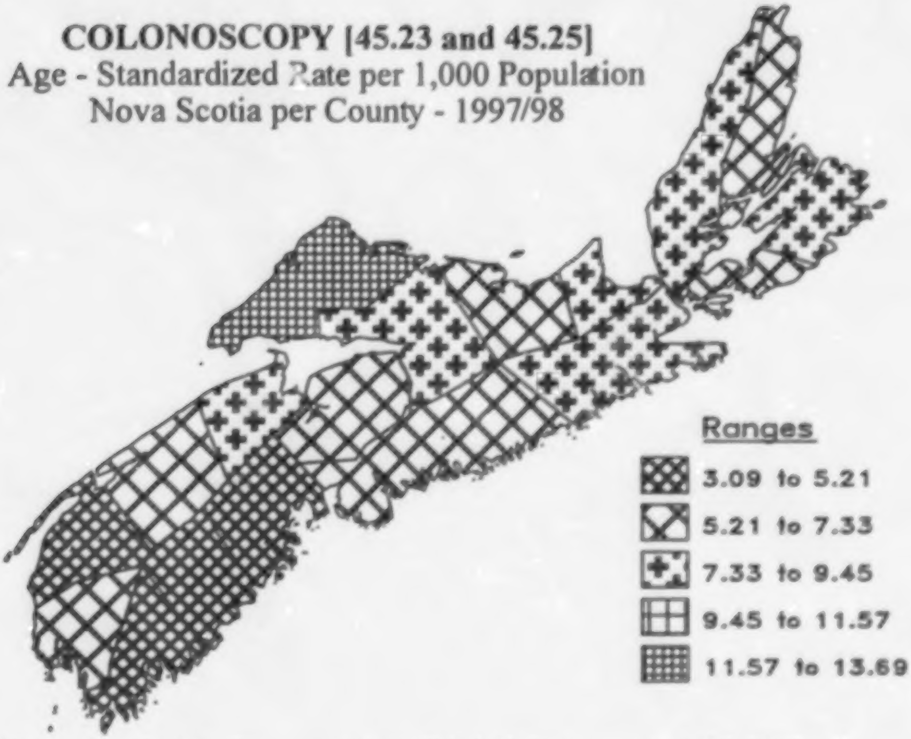


BILATERAL MYRINGOTOMY AND TUBES
[20.01]

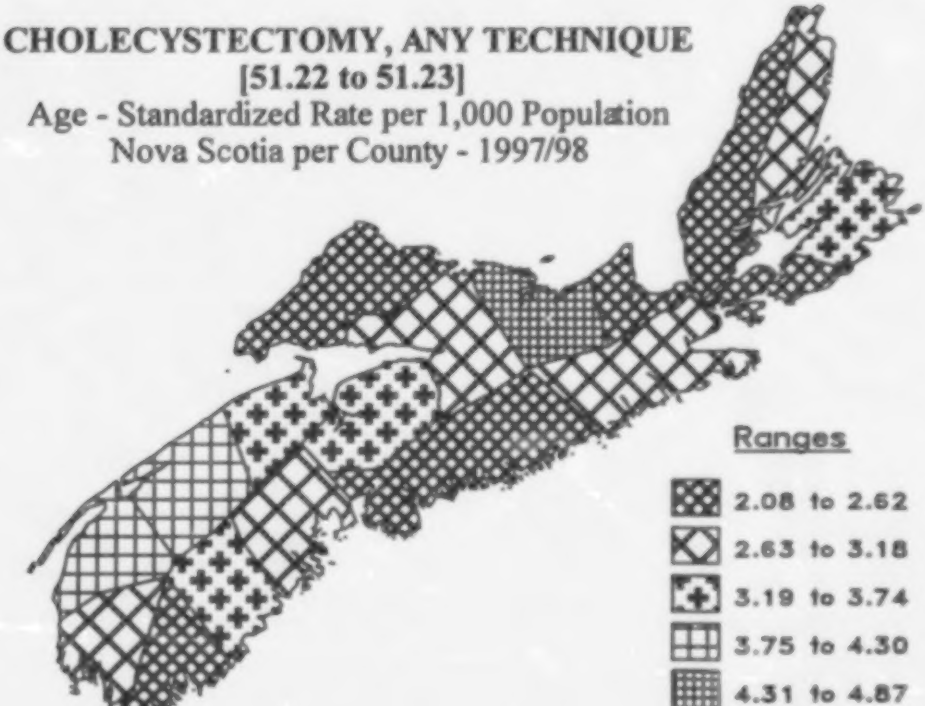
Age - Standardized Rate per 1,000 Population
Nova Scotia per County - 1997/98



COLONOSCOPY [45.23 and 45.25]
Age - Standardized Rate per 1,000 Population
Nova Scotia per County - 1997/98



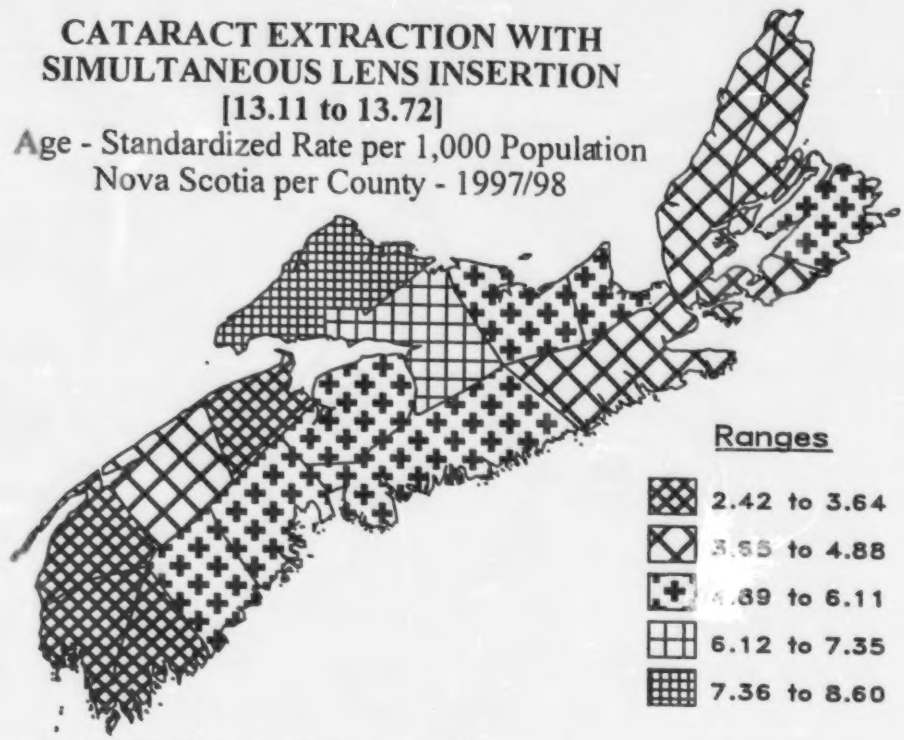
CHOLECYSTECTOMY, ANY TECHNIQUE
[51.22 to 51.23]
Age - Standardized Rate per 1,000 Population
Nova Scotia per County - 1997/98



CATARACT EXTRACTION WITH SIMULTANEOUS LENS INSERTION

[13.11 to 13.72]

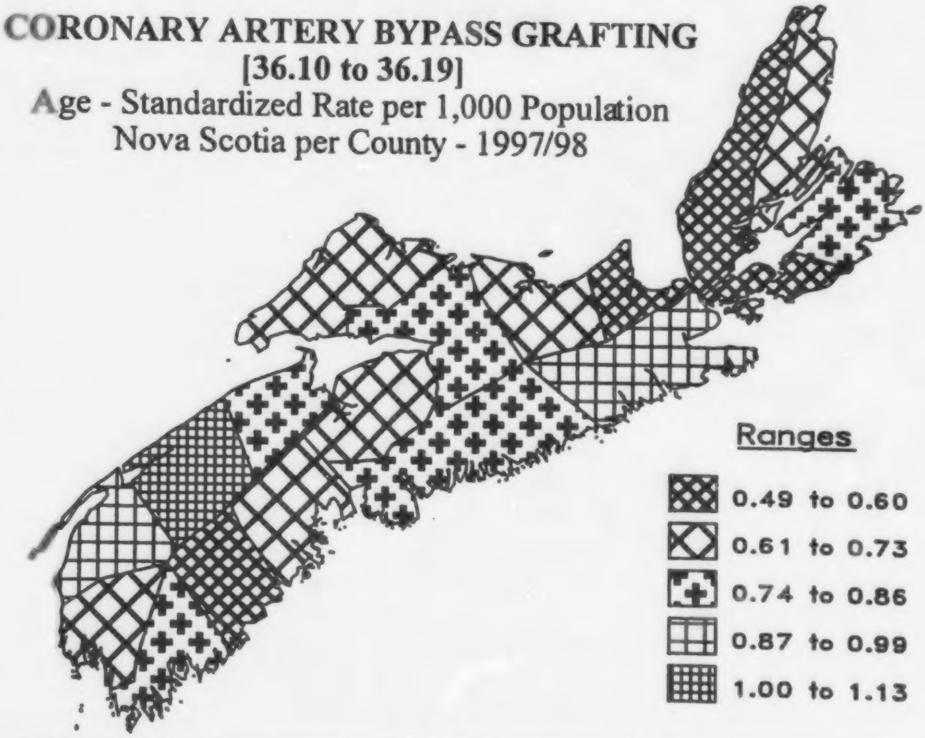
Age - Standardized Rate per 1,000 Population
Nova Scotia per County - 1997/98



CORONARY ARTERY BYPASS GRAFTING

[36.10 to 36.19]

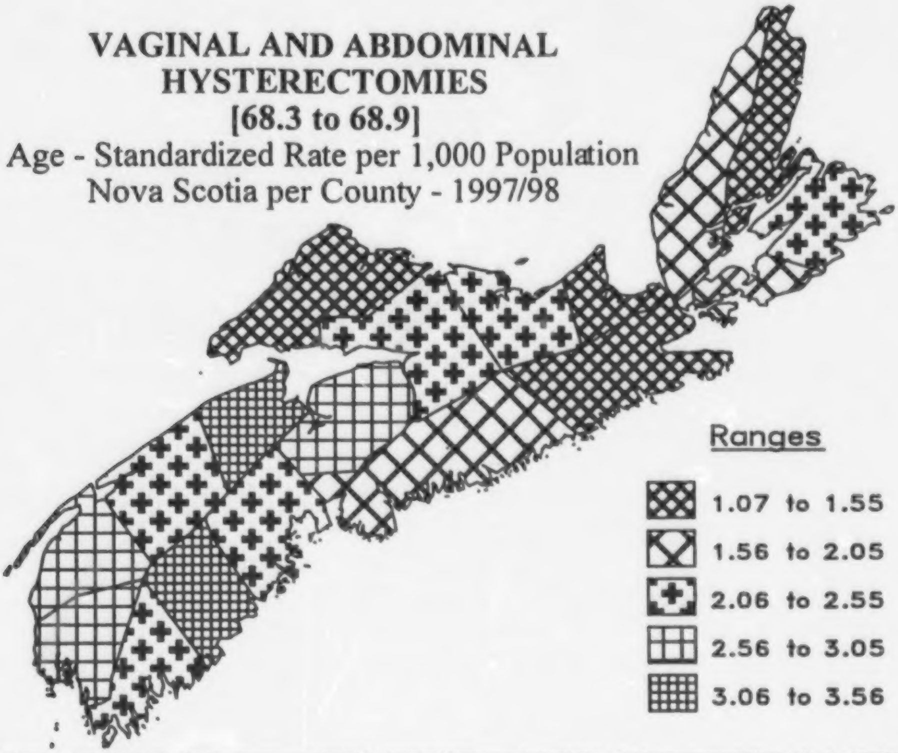
Age - Standardized Rate per 1,000 Population
Nova Scotia per County - 1997/98



VAGINAL AND ABDOMINAL HYSTERECTOMIES

[68.3 to 68.9]

Age - Standardized Rate per 1,000 Population
Nova Scotia per County - 1997/98



SLIDE INDICES

Pages One Through Three - 143 Slides
By The Health Information and Evaluation Section
Nova Scotia Department of Health

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5. Patient Days per 1000 Population - Crude Rates
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Data Dictionary

DATA DICTIONARY - ANNUAL REPORT 1997/98

A NOTE ON THIS DICTIONARY

This dictionary was designed for use with the Annual Report (1997/1998). It was compiled by the Health Information and Evaluation Section, Nova Scotia Department of Health with consultation from the various programs whose data is presented herein. The Report consists of a slide show, a data dictionary, and an interpretive text. The interpretive text offers an overview of the graphical information within the Annual Report whereas the dictionary offers insights into the exact technical nature of the Report's information. The dictionary entries follow the Presentations 8™ slide show order which makes up the bulk of the 1997/98 Annual Report. The slides are grouped by topic or program area within the Department of Health (*e.g.* Tobacco Control or Addictions Services).

A NOTE ON DEFINITIONS

Although, the definitions and formulae found in this dictionary, especially in the acute care sections, are the result of several years work and refinement, they owe their content to two main sources. Diagnostic and procedural codes, as well as their definitions, are found in The Educational Annotation of ICD-9-CM, 4th. Edition, Volumes 1, 2, and 3, by Puckett, Craig D., 1997, Channel Publishing, Ltd., Reno Nevada. The Canadian Institute for Health Information (CIHI) Abstracting Manual provides national guidelines for hospital abstracting.

A NOTE ON READING DATA

There are many ways to present numerical information. Generally speaking, the more numerals to the right of the decimal point the more precise the number. Conversely, the fewer the numerals to the right of the decimal point the less precise the number and the more rounding error introduced. Difficulty arises when attempting to illustrate numerical information graphically. There must be a balance between precision and readability. If there are too many numerals after the decimal point, the graphical presentation will be messy and cluttered. Therefore, the graph or table will not be able to be read accurately and the information presented will be less useful.

In the slide show from this annual report, most graphs do not show numerals to the right of the decimal place, as an aid to readability. By aiming for a clear presentation of data the overall usefulness of the graph increases. However, since data are shown in a rounded form, a small amount of rounding error is introduced. This error is negligible and does not effect the precision of this slide show in any meaningful way. The Health Information and Evaluation Section, NSDoH, has the original data tables for each slide including all numerals to the right of the decimal place (where possible).

Not all data presented in the slide show are decimal free. Where the variation between data points is small or where the Y-axis scale is less than 10 units, the data are then illustrated with one numeral to the right of the decimal place.

Issues regarding data presentation are not the only considerations necessary to read this annual report properly. Another set of considerations is the manner in which data are created. Under certain circumstance data which should be exactly the same, for instance a selected procedure rate per 1000 population, is different in consecutive slides. This is due to several factors including: different definitions, different data sources, crude rate versus age-standardized rate and so on. Neither number is incorrect, they are just differently formulated. Therefore, continual reference to the details in this data dictionary will allow the reader to make informed use of the data presented in the preceding slide show.

A NOTE ON RATES[1]

Different geographic areas or different time periods may not have similar population structures, *e.g.*, there may be different proportions of young and old people, male and female, *etc.*. For this discussion mortality rates will be used throughout. Mortality rates will be different at different times and locations.

A crude, or unadjusted, rate is calculated by taking the number of deaths in a geographic area in a period of time and dividing that number by the population (usually taken at the midpoint of the time period) in that geographic area, *i.e.*:

$$\text{Deaths}/\text{Population}$$

To avoid decimals, it is customary to express this as a rate per 100,000 persons:

$$\text{Deaths}/\text{Population} \quad X\ 100{,}000$$

An additional step can be taken to adjust these rates to correct for population differences through a process called standardization.

Process to standardize rates:

- A crude rate for each specific age (and sex) cohort (for example women aged 15 to

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[1] Information on crude and age/sex-standardized rates was provided by Dr. David Elliott, Health Information and Evaluation Section, Nova Scotia Department of Health.

19) is divided by the population estimate for the same cohort.

- These crude rates are multiplied by a weight (calculated by dividing the 1991 Canadian population in the specific cohort by the total population)
- The weighted rates are then added together across all age (and sex) cohorts to produce an age (and sex) standardized mortality rate.

The process of standardizing removes the effects of age (and/or sex) in a population. The resulting age (and sex) standardized rate provides a fairer comparison between geographic areas and different time periods than does the crude rate.

THE SLIDES

1. ANNUAL REPORT - 1997/98

2. ANNUAL REPORT - DATA NOTES - A Guide to Using the Data

3. ACUTE CARE - Part One

4. PATIENT DAYS PER 1000 POPULATION - Nova Scotia - 1990/91 to 1997/98

Background: Patient Days per 1000 Population - Inpatient separations from hospital and corresponding patient days of care expressed as a rate per 1000 population for a specified time period.

Formula: (The total days stay of those patients separated from hospital / the yearly N. S. population estimate) X 1000.

Incl: Includes acute medical, surgical, psychiatric hospital days, and rehabilitation (non-acute).

Excl: Excludes Veterans Affairs of Canada (VAC) , newborns, and out-of-province patients.

Source: Nova Scotia Department of Health/Admission-Separation Discharge System (NSDoH ASD hereafter) 1990/91 to 1994/95; Nova Scotia Department of Health/Canadian Institute of Health Information Discharge Abstracting Database (NSDoH CIHI DAD hereafter) 1995/96 to 1997/98. Population figures are from Statistics Canada population estimates as of September 1998.

5. PATIENT DAYS PER 1000 POPULATION - Crude Rates per 1000 Population by Region of Residence - 1997/98 - Excluding Newborns

Background: Patient Days per 1000 Population - Inpatient separations from hospital and corresponding patient days of care by region of patient's residence, expressed as a rate per 1000 population for a specified time period.

Formula: (The total days stay of those patients separated from hospital by age group / the yearly N.S. population estimate by region) **X** 1000.

Incl: Includes acute medical, surgical, psychiatric hospital days, and rehabilitation (non-acute).

Excl: Excludes Veterans Affairs of Canada (VAC) , newborns, and out-of-province patients.

Source: CIHI DAD, NSDoH, Statistics Canada.

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6. PATIENT DAYS PER 1000 POPULATION - Rates per 1000 Population Age-Standardized to the 1991 Canadian Population - by Region of Residence - 1997/98 - Excluding Newborns

Background: Patient Days per 1000 Population - Inpatient separations from hospital and corresponding patient days of care by region of patient's residence, expressed as a rate per 1000 population for a specified time period.

Formula: ((The total days stay of those patients separated from hospital by age group / the yearly N.S. population estimate by region) **X** Standardizing Process) **X** 1000 .

Incl: Includes acute medical, surgical, psychiatric hospital days, and rehabilitation (non-acute).

Excl: Excludes Veterans Affairs of Canada (VAC) , newborns, and out-of-province patients.

Source: CIHI DAD, NSDoH, Statistics Canada.

7. PATIENT DAYS PER 1000 POPULATION - Interprovincial Comparisons 1997/98 - Quebec 1996/97

Background:	Patient Days per 1000 Population - Inpatient separations from hospital and corresponding patient days of care expressed as a rate per 1000 population for a specified time period.
Formula:	(The total days stay of those patients separated from hospital / the yearly N.S. population estimate) **X** 1000.
Incl:	Includes psychiatric hospital days and long-stay days.
Note:	The inclusion and exclusion criteria for acute care patient days vary considerably among the provinces.
Source:	Data from Nova Scotia and other provinces were obtained from the CIHI Nova Scotia 1997/98 database and the CIHI National Database, 1997/98.

8. BEDS PER 1000 POPULATION - Nova Scotia 1990/91 to 1997/98

Background:	The number of acute care beds per unit population on a provincial level.
Formula:	(The total number of acute care beds / the yearly N. S. population estimate) **X** 1000.
Incl:	Includes acute care, mental health, and rehabilitation services.
Excl:	Excludes Veterans Affairs of Canada (VAC) beds, Detoxification Beds, and Level 2 beds.
Source:	Operations and Regional Support, NSDoH.

9. BEDS PER 1000 POPULATION - Interprovincial Comparisons Nova Scotia 1997/98 and Other Provinces 1996/97

Background:	The number of acute care beds per unit population on a national level.
Formula:	(The total number of acute care beds / the yearly provincial population estimate) **X** 1000.
Incl:	Includes acute care, mental health, and rehabilitation services.

14. ALTERNATE LEVEL OF CARE (ALC) DAYS - Per 1000 Population - Interprovincial Comparisons 1997/98

Background: Alternate Level of Care (ALC hereafter) Days per 1000 population – corresponding patient days of care for inpatient separations provided to a patient who has finished the acute care phase of his/her treatment. ALC status is indicated by the physician or designated other. These patients still occupy an acute care bed while awaiting transfer to another form of care, for example, chronic care, long term care, or rehabilitation.

Formula: (The total of the ALC length of stay of those patients separated from hospital / the yearly provincial population estimates) **X** 1000.

Source: Data from Nova Scotia and other provinces were obtained from CIHI National Database 1997/98. Definitions of this indicator may vary slightly between provinces.

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15. ALTERNATE LEVEL OF CARE (ALC) DAYS PER 1000 POPULATION - Crude Rates per 1000 Population by Hospital Region

Background: Alternate Level of Care (ALC hereafter) Days per 1000 population – corresponding patient days of care for inpatient separations provided to a patient who has finished the acute care phase of his/her treatment. ALC status is indicated by the physician or designated other. These patients still occupy an acute care bed while awaiting transfer to another form of care, for example, chronic care, long term care, or rehabilitation.

Formula: (The total of the ALC length of stay of those patients separated from hospital / the 1997/98 Nova Scotia Regional population estimates) **X** 1000.

Source: Data for Nova Scotia were obtained from CIHI National Database 1997/98.

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16. MAY NOT REQUIRE HOSPITALIZATION (MNRH) - Separations and Days - By Hospital Region 1997/98

Background: May not require hospitalization (MNRH hereafter) separations and days refer to those diagnoses and procedures for which the patients do not necessarily require hospitalization. For example sinusitis, tonsillectomy, and adenoidectomy are counted as MNRH's. The various

MNRH diagnoses and procedures do not exclude the possibility of hospitalization, however, they do not demand it either. In other words this measure encompasses a 'grey-area' of hospital admissions and therefore resource utilization.

Formula: The number of hospital separations and the number of days in hospital per separation for all diagnoses and procedures coded as MNRH.

Source: Data for Nova Scotia were obtained from CIHI National Database 1997/98.

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17. ACUTE CARE - Part Two

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18. PERCENTAGE OF ELECTIVE SURGERY PERFORMED ON THE DAY OF ADMISSION - Nova Scotia - 1990/91 to 1997/98

Background: Same Day Admission surgery is a program where elective surgery is performed on the day of hospital admission (admission date=procedure date) with all preparatory investigation completed prior to admission. Such pre-admission testing practices can decrease unnecessary and expensive days spent in hospital. Surgical cases are found using the procedure location of main operating room or endoscopic room 1995/96 to 1997/98.

Formula: (The number of elective surgical patient separations performed on the day of hospital admission / the total number of separations from patients having elective surgery) **X** 100.

Incl: Out-of-province patients and newborns are included.

Source: NSDoH ASD 1990/91 to 1994/95; NSDOH CIHI DAD 1995/96 to 1997/98, NSDoH.

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19. PERCENTAGE OF ELECTIVE SURGERY PERFORMED ON THE DAY OF HOSPITAL ADMISSION - By Region of Hospitalization - 1997/98

Background: Same Day Admission surgery is a program where elective surgery is performed on the day of admission (admission date = procedure date) with all preparatory investigation completed outside of hospital prior to admission. Such pre-admission testing practices can decrease unnecessary and expensive days spent in hospital. Surgical cases are found using the procedure location of main operating room or endoscopic room.

Formula: (The number of elective surgical patient separations performed on the day of hospital admission / the total number of separations from patients having elective surgery) X 100.

Incl: Out-of-province patients and newborns are included.

Source: NSDoH ASD 1990/91 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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20. DAY SURGERY AS A PERCENTAGE OF ALL SURGERY - Nova Scotia - 1990/91 to 1997/98

Background: Principal day surgery procedures as a percentage of all principal surgical procedures. Day surgery is a service provided to a patient who is pre-booked. NSDoH's *OR Funding Formula* was used to identify surgical procedures prior to and including 1994/95. CIHI Med Surg Indicator for 1995/96 to 1997/98 was used.

Formula: (The total number of Day surgery cases / the number of Day surgery cases + number of inpatient surgery cases) X 100.

Incl: Newborns are included.

Excl: Procedures performed in Ambulatory Care or Outpatient Clinical settings are not included.

Source: NSDoH ASD System 1990/91 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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21. DAY SURGERY AS A PERCENTAGE OF ALL SURGERY - By Region of Hospitalization

Background: Principal day surgery procedures as a percentage of all principal surgical procedures. Day surgery is a service provided to a patient who is pre-booked. NSDoH's *OR Funding Formula* was used to identify surgical procedures prior to and including 1994/95. CIHI Med Surg Indicator for 1995/96 to 1997/98 was used.

Formula: (The total number of Day surgery cases / the number of Day surgery cases + number of inpatient surgery cases) X 100.

Incl: Newborns are included.

Excl: Procedures performed in Ambulatory Care or Outpatient Clinical settings are not included.

Source: NSDoH CIHI DAD, NSDoH.

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22. DAY SURGERY AS A PERCENTAGE OF ALL SURGERY - Interprovincial Comparisons - 1997/98

Background: Principal day surgery procedures as a percentage of all principal surgical procedures. Day surgery is a service provided to a patient who is pre-booked. NSDoH's *OR Funding Formula* was used to identify surgical procedures prior to and including 1994/95. CIHI Med Surg Indicator for 1995/96 to 1997/98 was used.

Formula: (The total number of Day surgery cases / the number of Day surgery cases + number of inpatient surgery cases) X 100.

Incl: Newborns are included.

Excl: Procedures performed in Ambulatory Care or Outpatient Clinical settings are not included.

Source: NSDoH CIHI DAD, NSDoH.

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23. ELECTIVE DAY SURGERY AS A PERCENTAGE OF ALL ELECTIVE SURGERY - By Region of Hospitalization - 1997/98

Background: Principal day surgery procedure cases as a percentage of all principal surgical procedure cases. Day surgery is a service provided to a patient who is pre-booked. The service requires a sterile environment and recovery procedures and, do not require admission to an inpatient bed. Day surgery and inpatient surgical cases are based on elective separations only. To identify surgical cases CIHI's "principal operative procedure" code was applied and locate the main operating room or endoscopic room. Day surgeries have traditionally been pre-booked. Several facilities prefer to only report on elective operating room procedures to provide a more accurate picture of potential utilization and / or improvements.

Formula: (The total number of elective Day surgery cases / the number of elective Day surgery cases + number of elective inpatient surgery cases) X 100.

Incl: Newborns are included.

Excl: Procedures performed in Ambulatory Care settings are not included.

Source: NSDoH CIHI DAD, NSDoH.

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24. INGUINAL HERNIA REPAIRS PERCENTAGE DONE AS DAY SURGERY- Nova Scotia - 1992/93 to 1997/98

Background: Repair of a hernia (bilateral or unilateral) in the groin area of the body. ICD-9-CM procedure codes 53.0-.3 were used.

Formula: (The number of principal procedures (i.e. inguinal hernia repairs) performed on a Day surgery basis / (the number of principal procedures performed on a Day surgery basis + the number performed on an inpatient basis)) X 100.

Source: NSDoH ASD DAD System, 1992/3 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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25. LAPAROSCOPIC CHOLECYSTECTOMIES - Percentage Performed as Day Surgery - Nova Scotia 1992/93 to 1997/98

Background: Removal of the gallbladder, laparoscopically (by scope) . Cholecystectomy ICD-9-CM procedure code 51.23 was used.

Formula: (The number of principal procedures (i.e. laparoscopic cholecystectomies) performed on a Day surgery basis / (the number of principal procedures performed on a Day surgery basis + the number performed on an inpatient basis)) X 100.

Source: NSDoH ASD System 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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26. CARPAL TUNNEL RELEASE - Percentage Performed as Day Surgery - Nova Scotia - 1992/93 to 1997/98

Background: The surgical relief of compression of the median nerve at the wrist. Carpal tunnel release procedure code 04.43 was used.

Formula: (The number of principal procedures (i.e. carpel tunnel releases) performed on a Day surgery basis / (the number of principal procedures performed on a Day surgery basis + the number performed on an inpatient basis)) X 100.

Source: NSDoH ASD System 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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27. CATARACT EXTRACTIONS PERCENTAGE DONE AS DAY SURGERY - Nova Scotia - 1992/93 TO 1997/98

Background: Extraction of a cataract from the lens of the eye. ICD-9-CM procedure codes 13.11 to 13.72 were used.

Formula: (The number of principal procedures (i.e. cataract extractions) performed on a Day surgery basis / (the number of principal procedures performed on a Day surgery basis + the number performed on an inpatient basis)) X 100.

Source: NSDoH ASD System 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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28. CATARACT EXTRACTIONS NOVA SCOTIA - Principal Procedures Rates per 100,000 Age -Standardized to the 1991 Canadian Population

Background: Extraction of a cataract from the lens of the eye. ICD-9-CM procedure codes 13.11 to 13.72 were used.

Formula: ((The number of principal procedures performed (i.e. Cataract Extractions) per Region / the population estimate per Region) X Standardizing Process) X 100,000.

Source: NSDoH ASD System 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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29. CATARACT EXTRACTIONS BY REGION OF RESIDENCE - Principal Procedures Rates per 100,000 Age-Standardized to the 1991 Canadian Population

Background: Extraction of a cataract from the lens of the eye. ICD-9-CM codes 13.11 to 13.72 were used.

Formula: ((The number of principal procedures performed (i.e. Cataract Extractions) per Region / the population estimate per Region) X Standardizing Process) X 100,000.

Source: NSDoH CIHI DAD, NSDoH.

30. CHOLECYSTECTOMIES IN CANADA & NOVA SCOTIA - Principal Procedures Only - Crude Rates per 100,000 Population

Background: Removal of the gallbladder, all procedural approaches, both open and closed (by scope) . ICD-9-CM procedure codes 51.22 (total or open cholecystectomy) and 51.23 (laparoscopic) were used.

Formula: ((The total number of open and laparoscopic cholecystectomy procedure) / the Nova Scotia population estimates) X 100,000.

Note: Canadian figures represent in-patient principal procedures only.

Source: Statistics Canada *Surgical Procedures & Treatments* annual reports, 1984/85 to1993/94; data unavailable 1994/95 to 1997/98; NSDoH ASD 1984/85 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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31. CHOLECYSTECTOMIES IN NOVA SCOTIA - Principal Procedures Rates per 100,000 - Age-Standardized to the 1991 Canadian Population

Background: Removal of the gallbladder, all approaches, open and closed (by scope) . ICD-9-CM procedure codes 51.22 (total or open cholecystectomy) and 51.23 (laparoscopic) were used.

Formula: ((The number of principal procedures performed (i.e. Cholecystectomies) per Region / the population estimate per Region) X Standardizing Process) X 100,000.

Source: NSDoH ASD System 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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32. CHOLECYSTECTOMIES BY REGION OF RESIDENCE - 1996/97 - Principal Procedures Rates per 100,000 Age-Standardized to the 1991 Canadian Population

Background: Removal of the gallbladder, all procedural approaches, both open and closed (by scope). ICD-9-CM procedure codes 51.22 (total or open cholecystectomy) and 51.23 (laparoscopic) were used.

Formula: ((The number of principal procedures (open and laparoscopic) performed (i.e. Cholecystectomies) per Region / the population estimate per Region) X Standardizing Process) X 100,000.

Source: NSDoH CIHI DAD, NSDoH.

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33. LAPAROSCOPIC CHOLECYSTECTOMIES - As a Percentage of All Cholecystectomies - Nova Scotia - 1992/93 to 1997/98

Background: Removal of the gallbladder, all approaches, open and closed (by scope) . ICD-9-CM procedure codes 51.22 (total or open cholecystectomy) and 51.23 (laparoscopic) were used.

Formula: (The number of laparoscopic cholecystectomies performed / ((the number of total cholecystectomies + performed on an inpatient basis) **X** 100.

Source: NSDoH ASD 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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34. TOTAL HIP REPLACEMENTS - Crude Rates per 100,000 Population - Nova Scotia - 1992/93 to 1997/98

Background: Surgical removal of the hip joint with replacement by a synthetic hip joint. ICD-9-CM code 81.51 was used.

Formula: (The number of principal procedures performed (i.e. Total Hip Replacements) per Region / the population estimate per Region) **X** 100,000.

Source: NSDoH ASD System 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to1997/98, NSDoH.

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35. TOTAL HIP REPLACEMENTS - Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia 1992/93 to 1997/98

Background: Surgical removal of the hip joint with replacement by a synthetic hip joint. ICD-9-CM code 81.51 was used.

Formula: ((The number of principal procedures performed (i.e. Total Hip Replacements) per Region / the population estimate per Region) **X** Standardizing Process) **X** 100,000.

Source: NSDoH ASD System 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to1997/98, NSDoH.

36. TOTAL HIP REPLACEMENTS - 1997/98 by Region of Residence Rates per 100,000 Age-Standardized to the 1991 Canadian Population

Background: Surgical removal of the hip joint with replacement by a synthetic hip joint. ICD-9-CM procedure code 81.51 was used.

Formula: ((The number of principal procedures performed (i.e. Total Hip Replacements) per Region / the population estimate per Region) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD, NSDoH.

37. TOTAL KNEE REPLACEMENTS - Crude Rate per 100,000 Population - Nova Scotia - 1992/93 to 1997/98

Background: Surgical removal of the knee joint with replacement by a synthetic knee joint. ICD-9-CM procedure code 81.54 was used.

Formula: (The number of principal procedures performed (i.e. Total Knee Replacements) per Region / the population estimate per Region) **X** 100,000.

Source: NSDoH ASD System 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

38. TOTAL KNEE REPLACEMENTS - Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia 1992/93 to 1997/98

Background: Surgical removal of the knee joint with replacement by a synthetic knee joint. ICD-9-CM procedure code 81.54 was used.

Formula: ((The number of principal procedures performed (i.e. Total Knee Replacements) per Region / the population estimate per Region) **X** Standardizing Process) **X** 100,000.

Source: NSDoH ASD System 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

39. TOTAL KNEE REPLACEMENTS - 1997/98 Rates per 100,000 by Region of Residence Age-Standardized to the 1991 Canadian Population

Background: Surgical removal of the knee joint with replacement by a synthetic knee joint. ICD-9-CM procedure code 81.54 was used.

Formula: ((The number of principal procedures performed (i.e. Total Knee Replacements) per Region / the population estimate per Region) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD, NSDoH.

40. HYSTERECTOMIES CANADA AND NOVA SCOTIA - Crude Rates per 100,000 Population

Background: Removal of the uterus. Hysterectomy procedure codes used by Statistics Canada include only 80.3 (total abdominal hysterectomy) and 80.4 (vaginal hysterectomy) from the Canadian Classification of Procedures. The Nova Scotia data uses the ICD-9-CM procedure codes rather than the Canadian Classification of Procedures. The two coding systems are approximately equivalent.

Formula: (The number of hysterectomies / the Nova Scotia population estimates) **X** 100,000.

Incl: Nova Scotia used ICD-9-CM procedure codes include 68.3 subtotal abdominal hysterectomy, 68.4 total abdominal hysterectomy, 68.5 vaginal hysterectomy, 68.6 radical abdominal hysterectomy, 68.7 radical vaginal, 68.8 pelvic evisceration and 68.9 other and unspecified hysterectomy.

Source: Statistics Canada Surgical Procedures & Treatments annual reports, 1984/85 to 1993/94; data unavailable 1994/95 to 1997/98; NSDoH ASD System 1984/85 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

41. HYSTERECTOMIES - Crude Rates per 100,000 Population - 1992/93 to 1997/98

Background: Removal of the uterus.

Formula: (The number of principal procedures performed (i.e. Hysterectomies) per Region / the population estimate per Region) **X** 100,000.

Incl: Nova Scotia used ICD-9-CM procedure codes include 68.3 subtotal abdominal hysterectomy, 68.4 total abdominal hysterectomy, 68.5 vaginal hysterectomy, 68.6 radical abdominal hysterectomy, 68.7 radical vaginal, 68.8 pelvic evisceration and 68.9 other and unspecified hysterectomy.

Source: NSDoH ASD System 1992/93- 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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42. **HYSTERECTOMIES - Rates per 100,000 Age Standardized to the 1991 Canadian Population - Nova Scotia 1992/93 to 1997/98**

Background: Removal of the uterus.

Formula: ((The number of principal procedures performed (i.e. Hysterectomies) per Region / the population estimate per Region) **X** Standardizing Process) **X** 100,000.

Incl: Nova Scotia used ICD-9-CM procedure codes include 68.3 subtotal abdominal hysterectomy, 68.4 total abdominal hysterectomy, 68.5 vaginal hysterectomy, 68.6 radical abdominal hysterectomy, 68.7 radical vaginal, 68.8 pelvic evisceration and 68.9 other and unspecified hysterectomy.

Source: NSDoH ASD System 1992/93- 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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43. **HYSTERECTOMIES - By Region of Residence - 1997/98 Rates per 100,000 - Age-Standardized to the 1991 Canadian Population**

Background: Removal of the uterus.

Formula: ((The number of principal procedures performed (i.e. Hysterectomies) per Region / the population estimate per Region) **X** Standardizing Process) **X** 100,000.

Incl: Nova Scotia used ICD-9-CM procedure codes include 68.3 subtotal abdominal hysterectomy, 68.4 total abdominal hysterectomy, 68.5 vaginal hysterectomy, 68.6 radical abdominal hysterectomy, 68.7 radical vaginal, 68.8 pelvic evisceration and 68.9 other and unspecified hysterectomy.

Source: NSDoH CIHI DAD, NSDoH.

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44. ACUTE CARE - Part Three

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45. CARDIAC CATHETERIZATIONS - Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia - 1992/93 to 1997/98

Background: The insertion of a cardiac catheter into the right or left heart chambers (atria and ventricles) for the detection of cardiac abnormalities. Daypatient cardiac catheterizations have not been coded at the QEII unless a myocardial biopsy or angioplasty was performed during the same operative episode. (Effective 1999/2000, all day surgery procedures performed in the Cardiac Catheterization Lab will be captured for CIHI.) Procedure codes 37.21 to 37.23 were used.

Formula: ((The number of principal procedures performed (i.e. Cardiac Catheterizations) per Region / the population estimate per Region) X Standardizing Process) X 100,000.

Source: NSDoH ASD System 1992/93- 1994/95, 1995/96-96/97 CIHI DAD, NSDoH.

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46. CARDIAC CATHETERIZATIONS BY REGION OF RESIDENCE - 1997/98 Rates per 100,000 Age-Standardized to the 1991 Canadian Population

Background: The insertion of a cardiac catheter into the right or left heart chambers (atria and ventricles) for the detection of cardiac abnormalities. Daypatient cardiac catheterizations have not been coded at the QEII unless a myocardial biopsy or angioplasty was performed during the same operative episode. (Effective 1999/2000, all day surgery procedures performed in the Cardiac Catheterization Lab will be captured for CIHI.) Procedure codes 37.21 to 37.23 were used.

Formula: ((The number of principal procedures performed (i.e. Cardiac Catheterizations) per Region / the population estimate per Region) X Standardizing Process) X 100,000.

Source: NSDoH CIHI DAD, NSDoH.

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47. **CORONARY ANGIOPLASTIES - Rates per 100,000 Age-Standardized to the 1991 Canadian Population - Nova Scotia - 1992/93 to 1997/98**

Background: Dilation of an obstructed coronary artery or the procedural removal of a thickened coronary arterial intima (using a balloon-tipped catheter), inserted through the femoral or other artery, with or without infusion of a thrombus-destroying substance. Procedure codes 36.01 (single percutaneous transluminal coronary angioplasty - PTCA w/o thrombolytic) , 36.02 (single PTCA with thrombolytic) , and 36.05 (multiple vessel PTCA with/without thrombolytic were used) .

Formula: ((The number of principal procedures performed (i.e. Coronary Angioplasties) per Region / the population estimate per Region) **X** Standardizing Process) **X** 100,000.

Source: NSDoH ASD System 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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48. **CORONARY ANGIOPLASTIES BY REGION OF RESIDENCE - 1997/98 Rates per 100,000 Age-Standardized to the 1991 Canadian Population**

Background: Dilation of an obstructed coronary artery or the procedural removal of a thickened coronary arterial intima (using a balloon-tipped catheter), inserted through the femoral or other artery, with or without infusion of a thrombus-destroying substance. Procedure codes 36.01 (single percutaneous transluminal coronary angioplasty - PTCA w/o thrombolytic) , 36.02 (single PTCA with thrombolytic) , and 36.05 (multiple vessel PTCA with/without thrombolytic were used) .

Formula: ((The number of principal procedures performed (i.e. Coronary Angioplasties) per Region / the population estimate per Region) **X** Standardizing Process) **X** 100,000.

Source: NSDoH CIHI DAD, NSDoH.

49. CORONARY ARTERY BYPASS GRAFT - Rates per 100,000 Age-Standardized to the 1991 Canadian Population

Background: Restoration of coronary blood flow by a tubular surgical bypass (grafted mammary artery or saphenous vein) of an occluded coronary artery. ICD-9-CM procedure codes 36.10-36.19 were used.

Formula: ((The number of principal procedures performed (i.e. coronary artery bypass graft (CABG's)) per Region / the population estimate per Region) **X** Standardizing Process) **X** 100,000.

Source: NSDoH ASD 1992/93 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

50. CORONARY ARTERY BYPASS GRAFT BY REGION OF RESIDENCE - 1997/98 Rates per 100,000 Age-Standardized to the 1991 Canadian Population

Background: Restoration of coronary blood flow by a tubular surgical bypass (grafted mammary artery or saphenous vein) of an occluded coronary artery. ICD-9-CM procedure codes 36.10-36.19 were used.

Formula: ((The number of principal procedures performed (i.e. coronary artery bypass graft (CABG's)) per Region / the population estimate per Region) **X** Standardizing Process) **X** 100,000.

Source: NSDoH, CIHI DAD, NSDoH.

51. CARDIOVASCULAR SURGERY WAIT TIMES (URGENT) - by Category and Month - April 1997 to March 1998

Background: Maximum wait time in days for cardiovascular surgery for urgent patient, and by month. **Urgent** patients are critically ill and cannot be discharged from hospital prior to receiving surgery. They have failed maximal medical therapy and remain unstable. The current wait time standard is 7 days. **Semi-Urgent "A"** patients are unstable, have failed medical therapy and are at significant risk of heart attack or heart failure and mortality. In many instances, patients are transferred back to their regional hospital while arrangements are being made to have surgery. The current wait time standard is 2-3 weeks. **Semi-Urgent "B"** patients have coronary artery disease and are doing poorly on medical therapy. They would have chest pain walking 1-2 blocks and are incapable of employment. If these patients can exercise greater than 2 mets (a met is a standardized score on a cardiac stress test) but less than

5 mets during a stress ECG test they fall into this category. The current standard wait time is 6-8 weeks.

Formula: The total number of days waiting between the procedure booking date (by the referring physician) and the date of the procedure.

Source: Divisions of Cardiology and Cardiovascular Surgery, QEII Monthly Wait Times.

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52. CARDIOVASCULAR SURGERY WAIT TIMES (ELECTIVE) - by Month - April 1997 to March 1998

Background: Maximum wait time in days for cardiovascular surgery for elective patient, and by month. **Elective** patients are stable on medical therapy; unable to work due to cardiac limitations; and felt to further improve with bypass surgery. The current waiting time standard is 3 months.

Formula: The total number of days waiting between the procedure booking date (by the referring physician) and the date of the procedure.

Source: Divisions of Cardiology and Cardiovascular Surgery, QEII Monthly Wait Times.

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53. NON-ELECTIVE READMISSIONS TO THE SAME HOSPITAL WITHIN ONE WEEK OF DISCHARGE 1997/98 - By Region of Hospitalization

Background: These non-elective readmission patients have been readmitted for a diagnosis which is the same or related to conditions treated in the previous admission to hospital. These readmissions are classified according to the CIHI Abstracting Manual guidelines.

Formula: (The number of readmissions (admission category = emergency or urgent) with same or related diagnosis within seven (7) days of previous treatment / the total number of patient separations (admission category = emergency or urgent)) **X** 100.

Incl: Urgent and emergent readmissions.

Excl: Elective readmissions, newborns, palliative care, chemotherapy and dialysis patients. This measure also excludes patient services 51, 52, 53, and 59.

Source: NSDoH CIHI DAD, NSDoH.

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54. NON-ELECTIVE READMISSIONS TO SAME HOSPITAL WITHIN ONE MONTH OF DISCHARGE 1997/98 - By Region of Hospitalization

Background: These non-elective readmission patients have been readmitted for a diagnosis which is the same or related to conditions treated in the previous admission to hospital. These readmissions are classified according to the CIHI Abstracting Manual guidelines.

Formula: (The number of readmissions (admission category = emergency or urgent) with same or related diagnosis within thirty (30) days of previous treatment / the total number of patient separations (admission category = emergency or urgent)) **X** 100.

Incl: Urgent and emergent readmissions.

Excl: Elective readmissions, newborns, palliative care, chemotherapy and dialysis patients. This measure also excludes patient services 51, 52, 53, and 59.

Source: NSDoH CIHI DAD, NSDoH.

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55. ACUTE CARE 'TOP TEN" CIHI MAJOR CLINICAL CATEGORIES - Nova Scotia - In-Patient Separations Only - 1997/98 - By Region of Hospitalization - Excludes Newborns

Background: The Canadian Institute for Health Information (CIHI) list a series of Major Clinical Categories (MCC hereafter) as a method to group individual diagnostic codes into meaningful categories. The arrangement of ten of these MCC's from the most frequent to the least frequent measures the amount of patients served, in hospital, per diagnostic cluster.

Formula: The number of in-patient separations per hospital region, excluding newborns per Major Clinical Classification.

Excl: Newborns and out-of-province patients are excluded.

Source: NSDoH CIHI DAD, NSDoH.

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56. ACUTE CARE 'TOP TEN" CIHI MAJOR CLINICAL CATEGORIES - Nova Scotia - In-Patient, Patient Days Only - 1997/98 - By Region of Hospitalization - Excludes Newborns

Background: The Canadian Institute for Health Information (CIHI) list a series of Major Clinical Categories (MCC hereafter) as a method to group individual diagnostic codes into meaningful categories. The arrangement of ten of these MCC's from the most frequent to the least frequent measures the length of time patients stayed in hospital, per diagnostic cluster.

Formula: The number of in-patient, patient days per hospital region, excluding newborns per Major Clinical Classification.

Excl: Newborns and out-of-province patients are excluded.

Source: NSDoH CIHI DAD, NSDoH.

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57. ACUTE CARE 'TOP TEN" CIHI MAJOR CLINICAL CATEGORIES - Nova Scotia - In-Patient Separations Only - 1997/98 - By Region of Hospitalization - Excludes Newborns - Women Only

Background: The Canadian Institute for Health Information (CIHI) list a series of Major Clinical Categories (MCC hereafter) as a method to group individual diagnostic codes into meaningful categories. The arrangement of ten of these MCC's from the most frequent to the least frequent measures the amount of patients served, in hospital, per diagnostic cluster for women only.

Formula: The number of in-patient separations per hospital region, excluding newborns per Major Clinical Classification for women only.

Excl: Newborns, men, and out-of-province patients are excluded.

Source: NSDoH CIHI DAD, NSDoH.

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58. ACUTE CARE 'TOP TEN" CIHI MAJOR CLINICAL CATEGORIES - Nova Scotia - In-Patient, Patient Days Only - 1997/98 - By Region of Hospitalization - Excludes Newborns

Background: The Canadian Institute for Health Information (CIHI) list a series of Major Clinical Categories (MCC hereafter) as a method to group individual diagnostic codes into meaningful categories. The arrangement of ten of these MCC's from the most frequent to the least frequent measures the length of time patients stayed in hospital, per diagnostic cluster for women only.

Formula: The number of in-patient, patient days per hospital region, excluding newborns per Major Clinical Classification for women only.

Excl: Newborns, men, and out-of-province patients are excluded.

Source: NSDoH CIHI DAD, NSDoH.

59. MENTAL HEALTH

60. MENTAL HEALTH PROGRAMS - In-Patient Separations - Adults Only (19 Years and Older) Nova Scotia - Excludes Forensic and Extended Care Units - 1997/98

Background: Mental Health services in Nova Scotia have developed a clustering of ICD-9-CM diagnosis codes for grouping similar diagnoses.

Formula: The sum of in-patient separations from each patient service (64 - psychiatry and /or 65 - pediatric psychiatry) for each diagnostic group for all hospitals with a designated psychiatric unit.

Source: NSDoH CIHI DAD, NSDoH.

61. MENTAL HEALTH PROGRAMS - Patient Days - Adults Only (19 Years and Older) Nova Scotia - Excludes Forensic and Extended Care Units - 1997/98

Background: Mental Health services in Nova Scotia have developed a clustering of ICD-9-CM diagnosis codes for grouping similar diagnoses.

Formula: The sum of in-patient days from each patient service (64 - psychiatry and /or 65 - pediatric psychiatry) for each diagnostic group for all hospitals with a designated psychiatric unit.

Source: NSDoH CIHI DAD, NSDoH.

62. MENTAL HEALTH PROGRAMS - In-Patient Separations - Children Only (18 Years and Younger) Nova Scotia - Excludes Forensic and Extended Care Units - 1997/98

Background: Mental Health services in Nova Scotia have developed a clustering of ICD-9-CM diagnosis codes for grouping similar diagnoses.

Formula: The sum of in-patient separations from each patient service (64 - psychiatry and /or 65 - pediatric psychiatry) for each diagnostic group for all hospitals with a designated psychiatric unit.

Source: NSDoH CIHI DAD, NSDoH.

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63. MENTAL HEALTH PROGRAMS - Patient Days - Children Only (18 Years and Younger) Nova Scotia - Excludes Forensic and Extended Care Units - 1997/98

Background: Mental Health services in Nova Scotia have developed a clustering of ICD-9-CM diagnosis codes for grouping similar diagnoses.

Formula: The sum of all in-patient days from each patient service (64 - psychiatry and /or 65 - pediatric psychiatry) for each diagnostic group for all hospitals with a designated psychiatric unit.

Source: NSDoH CIHI DAD, NSDoH.

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64. MENTAL HEALTH PROGRAMS PATIENT DAYS PER 1000 POPULATION - Acute Psychiatric Care by Region of Residence - Crude Rates per 1000 Population - 1997/98

Background: Patient Days per 1000 Population - Acute inpatient mental health patient days of care by region of patient's residence.

Formula: (The total days stay of those patients separated from hospital with a designated psychiatric unit (acute mental health care) by age group / the yearly Nova Scotia population estimates by region) **X** 1000. Use patient service codes 64.1 to 64.5, 64.7, 65.1, and 65.2.

Incl: Rate includes only acute psychiatric hospital days.

Excl: This indicator excludes separations from Forensic and Extended Care units and out-of-province residents.

Source: NSDoH CIHI DAD, NSDoH.

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65. MENTAL HEALTH PROGRAMS - AVERAGE LENGTH OF STAY - Acute Psychiatric Care - Adults Only Nova Scotia - 1992/93 to 1997/98

Background: Average Length of Stay for patients treated for psychiatric disorders in all Nova Scotia hospitals with a designated psychiatric unit. This definition includes acute psychiatric units in general and psychiatric hospitals. While adults usually occupy these units teenagers may also be admitted to acute psychiatric units. Adults are defined as 19 and over years of age (child mental health services end at 18 years of age) .

Formula: The total length of stay of adult psychiatric patients in hospital / the total separations for those same patients for a specified period of time.

Incl: Rate includes only acute psychiatric hospital days.

Excl: This indicator excludes separations from Forensic and Extended Care units and out-of-province residents.

Source: NSDoH ASD System, 1991/92 to 1994/95; NSDoH CIHI DAD 1995/96 to 1997/98, NSDoH.

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66. MENTAL HEALTH PROGRAMS AVERAGE LENGTH OF STAY – Acute Psychiatric Care - by Region of Residence - 1997/98

Background: Average Length of Stay for patients treated for psychiatric disorders in all Nova Scotia hospitals with a designated psychiatric unit by region of residence.

Formula: The total length of stay of psychiatric patients in hospital / the total separations for those same patients for a specified period of time.

Incl: This rate includes only acute psychiatric hospital days from acute psychiatric units in both general and psychiatric hospitals.

Excl: This indicator excludes separations from the Forensic and Extended Care units at the Nova Scotia Hospital and out-of-province residents.

Source: NSDoH CIHI DAD, NSDoH.

67. MENTAL HEALTH PROGRAMS - AMBULATORY CARE SERVICE LEVELS - Average MIS Visits per Client and Active MIS Clients per 1000 Population Rate

Background: **Visits per Client**: average MIS visits per client is an indicator of service intensity. Unlike the active client rate (discussed below) the visits per client indicator represents the number of total MIS visits (as defined by MIS guidelines) not unique clients, and is divided by the number of clients whose files were open during the reporting period. **Active Client Rate**: Active unique MIS clients per 1000 population (refers to unique Health Card numbers) . 'Active unique MIS clients' is an unique count of individuals treated within a given period, in this case, one year. The 1991 Statistics Canada Census population for Nova Scotia is used for the denominator.

Formula: **Visits per Client**: the total number of MIS visits / the number of clients with open cases during the time period under study. **Active Client Rate**: (the number of active unique MIS clients / the 1991 Statistics Canada Census population for Nova Scotia) **X** 1000.

Source: Mental Health Outpatient Information System, Annual Reports, NSDoH.

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68. MENTAL HEALTH PROGRAMS AMBULATORY CARE - Number of People Served - Mental Health Outpatient Information System (MHOIS) - Unique Clients - 1993/94 to 1997/98

Background: This is a unique count of the number of people served by the outpatient Mental Health Programs in Nova Scotia.

Formula: Number of active unique MIS clients served in N.S. within a specified time period (as captured by the Mental Health Outpatient Information System).

Source: Mental Health Outpatient Information System (MHOIS) , Annual Reports, NSDoH.

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69. MENTAL HEALTH PROGRAMS TOP DIAGNOSES - Outpatient Clinics (Ambulatory Care) - Adults (19 Years of Age Plus) - 1997/98

Background: The most common diagnoses of adult (19 plus years of age) clients treated in outpatient mental health programs in Nova Scotia during

1997/98. 'Diagnosis Deferred' occurs when mental health therapists either do not have enough exposure to a client (for example one visit) to make proper diagnoses or the problem is difficult to diagnosis and thus the diagnosis is deferred until which time an accurate one can be made.

Formula: List of the five highest numbers of diagnoses for adults (19 plus years of age) in outpatient clinics.

Source: MHOIS Reporting System, NSDoH.

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70. MENTAL HEALTH PROGRAMS TOP DIAGNOSES - Outpatient Clinics (Ambulatory Care) - Youth (18 Years and Under) - 1997/98

Background: The most common diagnoses of youth (under 18 years of age) clients treated in outpatient mental health programs in Nova Scotia during 1997/98. 'Diagnosis Deferred' occurs when mental health therapists either do not have enough exposure to a client (for example one visit) to make proper diagnoses or the problem is difficult to diagnosis and thus the diagnosis is deferred until which time an accurate one can be made.

Formula: List of the five highest numbers of diagnoses for youth (under 18 years of age) in outpatient clinics.

Source: MHOIS Reporting System, NSDoH.

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71. ADDICTION SERVICES PROGRAMS

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72. ADDICTION SERVICES PROGRAMS - Number of Clients Served - By Gender

Background: The total number of male and female clients who used Addiction Services programs in a given fiscal year. Addiction Services includes many program areas: Outpatient Services (O.P.S.) , Detoxification (Withdrawal Management) , Treatment Orientation Program (T.O.P.) , 28 day program, CORE services (Central Region only – includes education, orientation, structured treatment programs, and adolescent services) . Three out four regions have T.O.P. (Central Region does not). The 28 day programs are found in Eastern and Western Regions.

Formula: The total number of male and the total number of female clients (unique) who used Addiction Services programs in a given fiscal year.

Incl: This measure includes all Addiction Services Program Areas.

Source: Nova Scotia Addiction Services Program Statistics, NSDoH.

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73. ADDICTION SERVICES PROGRAMS - 1997/98 - Service Utilization Breakdown: Outpatient Services and Inpatient Services - Service Available in Each Region - Service Titles Vary Between Regions

Background: The number of clients in specified programs including: O.P.S. (Outpatient Services) ; Detoxification (Withdrawal Management), T.O.P. (Treatment Orientation Program) , 28 Day, and CORE (Central Region) .

Formula: The total number of clients in O.P.D., Detox, T.O.P., 28-Day, and CORE.

Source: Nova Scotia Addiction Services Program Statistics, NSDoH.

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74. PUBLIC HEALTH

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75. BREASTFEEDING RATES - NOVA SCOTIA - 1991 TO 1997 CANADA 1994 - The Rate is Based on Women Breastfeeding at Hospital Discharge

Background: Breast feeding rates refer to the relationship between the number of women breast-feeding at the time of hospital discharge and the total number of women giving birth, whose breast-feeding status is known at hospital discharge. This relationship is expressed as a percentage. **Note**: the number of women whose breast-feeding status was known at hospital discharge is not the same number as the total number of women delivering babies (it is slightly less) . Using the known breast-feeding status total as the denominator in this equation allows for increased precision in measuring breast-feeding rates.

Formula: (The number of women known to be breast-feeding at hospital discharge / the number of women whose breast-feeding status (yes or no) was known at hospital discharge) **X** 100.

Source: Nova Scotia Breast-feeding data were provided by the Reproductive Care Program (19/02/1999) . The Canadian rate was based on the publication: Survey of Routine Maternity Care and Practices in Canadian Hospitals, Canadian Institute of Child Health, Supply and Services, Canada, 1995.

76. INFLUENZA VACCINATION RATES - NOVA SCOTIA - Percentage of Adults Vaccinated (65 Years of Age Plus)

Background: The proportion of adults 65 years of age and older who receive an influenza vaccination for a specific influenza season.

Formula: (The number of elderly patients 65 years of age and older who are immunized / Nova Scotia population aged 65 years and older) X 100.

Source: Public Health Programs Section, NSDoH.

77. CHLAMYDIA RATES PER 100,000 POPULATION - Nova Scotia - 1984 to 1997; Canada 1991 to 1995

Background: Chlamydia is a sexually transmitted disease (STD) caused by the Chlamydia trachomatis bacterium. Most of those infected with Chlamydia trachomatis are young people under the age of 25[2]. Furthermore Chlamydia has been suggested as a cofactor in HIV infection and is extremely dangerous (in later stages of infection) to women[3]. Therefore this STD must be monitored in the best interest of the public.

Formula: (The number of chlamydia cases / Nova Scotia (for the Nova Scotian rate) and Canadian (for the Canadian rate)) X 100,000.

Source: Public Health Programs, NSDOH.

78. AIDS INCIDENCE PER 100,000 POPULATION - Nova Scotia - 1991-1997

Background: An illness characterized by laboratory evidence of HIV infection and, any one of 23 recognized "indicator" diseases.

Formula: (The number of people who were diagnosed with AIDS / the Nova Scotian population) X 100,000.

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[2] Guide to Clinical Preventive Services, 2nd. Edition, 1996, Report of the U.S. Preventive Services Task Force, Williams and Wilkins, Baltimore, Maryland, Page 326.

[3] Ibid.:325.

Source: Canadian Laboratory Centre for Disease Control, Ottawa, Report on AIDS, 1995, Supply and Services Canada and Chief Medical Officer of Health, NSDoH, 1998 with population estimates from Health Information and Evaluation Section, NSDoH, 1999.

79. CRUDE RATE OF HIV INCIDENCE PER 100,000 POPULATION- Nova Scotia - 1991 to 1997

Background: Human immunodeficiency virus. Serologic or other evidence of HIV infection in an individual who does not meet the case definition of AIDS. Public Health reports only those cases that are diagnosed in this province. If someone tests positive in New Brunswick, for example, and comes to Nova Scotia for treatment, they are not included in these statistics.

Formula: (The number of people newly diagnosed with HIV (incidence) within the Nova Scotia population / the Nova Scotia population estimate for the same time period) X 100,000.

Source: Chief Medical Officer of Health, NSDoH.

80. TOBACCO CONTROL UNIT

81. TOBACCO CONTROL UNIT SMOKING RATES - Adults Who Smoke - Nova Scotia and Canada

Background: Adult smoking is a difficult phenomena to report on as there are almost as many definitions of adult smoking as there are studies on smoking. This indicator, as it is used here, is a composite measure – made of three different surveys spanning five different years. All of them define "Smokers are those reported smoking cigarettes daily"[4].

Formula: (The number of adult daily smokers / the population estimated for a given time period and a given geopolitical area) **X** 100.

Source: General Social Survey, 1985 and 1991; N.A.D.S. 1989; Health Indicators Database, Statistics Canada, December 1996; and National Population Health Survey, 1994/95 and 1996/97, Statistics Canada, July 1998.

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[4] Notes on the summary page of the Health Indicators Database, for "Numbers of Smokers", Statistics Canada, December 1996.

82. **TOBACCO CONTROL UNIT SMOKING RATES - Nova Scotia Women Who Smoke During Pregnancy - 1991 to 1997 - Women Who Reported Smoking During Pregnancy at Hospital Discharge**

Background: This measure illustrates the comparison of women who smoke during pregnancy to the total number of pregnant women expressed as a percentage. The total number of pregnant women is based solely on those who are in hospital to deliver. It is possible that some pregnant women will not be captured in this manner. This measure also demonstrates the indirect impact of smoking awareness educational programs on expectant mothers.

Formula: (The total number of women (aged 0 to 35 plus years) who report smoking during their pregnancy (on discharge forms) / the total number of women (smokers and non-smokers) who have given birth) **X** 100.

Source: Nova Scotia Atlee Perinatal Database (NSAPD) , 1999.

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83. **TOBACCO CONTROL UNIT SMOKING RATES - Nova Scotia Youth Smoking - Among Grade 7, 9, 10, and 12 Students - for 1991, 1996, and 1998 - by Cigarette Consumption**

Background: The data on student smoking comes entirely from the Student Drug Use survey series. The authors define smoking as "... refers to smoking more than one cigarette in the 12 months prior to the survey, ...".[5] Please note that in 1991, the rate is based on at least one cigarette per year not more than one which is the definition used in 1996 and 1998. Those who smoke more than 10 cigarettes per day are considered frequent smokers.[6]

Formula: **More than one cigarette per year**: (The total number of students in grades 7, 9, 10, and 12 who report smoking at least more than one cigarette per year / the total number of students in grades 7, 9, 10, and 12 (who responded to the survey question)) **X** 100. **More than ten cigarettes per day**: (The total number of students in grades 7, 9, 10, and 12 who report smoking at least more than ten cigarettes per day /

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[5] Nova Scotia Student Drug Use 1996: Technical Report, 1996; Poulin, Christiane; Communications Nova Scotia, Drug Dependency Services Division, Nova Scotia Department of Health and Dalhousie University; page 4.

[6] Ibid.

the total number of students in grades 7, 9, 10, and 12 (who responded to the survey question)) **X** 100.

Source: Student Drug Use 1991: Technical Report; Student Drug Use 1996: Technical Report; and Student Drug Use 1998: Technical Report, Drug Dependency Services, NSDoH (1991) ; Drug Dependency Services, NSDoH and Dalhousie University (1996 and 1998) .

84. ENVIRONMENTAL TOBACCO SMOKE RATES - Environmental Tobacco Smoke (ETS) - Those Who Answered 'Yes' to "Does Anyone in this Household Smoke Regularly Inside the House?"[7] - (12 to 80 + Years of Age) - 1994/95 and 1996/97

Background: The National Population Health Survey in both 1994/95 and 1996/97 asked several questions regarding smoking. One question was whether or not the respondent lived with a smoker who smoked indoors (see above citation) . The cumulative answers to this question provide a measure of the prevalence of the exposure to environmental tobacco smoke (ETS) . The effects of environmental tobacco smoke (second-hand smoke) on non-smokers are varied however the presence of ETS constitutes a major health concern. This is not a measure of the amount of ETS just its prevalence.

Formula: (The number of those persons responding 'yes' to the question of whether they lived with a smoker who smokes indoors (see above citation) / the total population of the same age, per province (those bordering on the Atlantic Ocean) and Canada) X 100.

Source: National Population Health Survey, 1994/95 and 1996/97, Statistics Canada, 1995 and 1998.

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[7] Page 503, 1996-97 NPHS: Share File - Health, National Population Health Survey, 1996/97, Statistics Canada, Share Files: General and Health Files, Record Layout, Data Dictionary, Alpha and Topical Indexes, C.V. Tables, July 1988.

85. ENVIRONMENTAL TOBACCO SMOKE RATES - Environmental Tobacco Smoke (ETS) - Those Who Answered 'Yes' to "Does Anyone in this Household Smoke Regularly Inside the House?"[8] - (12 to 80 + Years of Age) - by Gender - 1996/97

Background: The National Population Health Survey in both 1994/95 and 1996/97 asked several questions regarding smoking. One question was whether or not the respondent lived with a smoker who smoked indoors (see above citation) . The cumulative answers to this question provide a measure of the prevalence of the exposure to ETS. The effects of environmental tobacco smoke (second-hand smoke) on non-smokers are varied however the presence of ETS constitutes a major health concern. This is not a measure of the amount of ETS just its prevalence.

Formula: (The number of those persons responding 'yes' to the question of whether one lived with a smoker who smokes indoors (see above citation) / the total Nova Scotian population of the same age by gender, per province (those bordering on the Atlantic Ocean) and Canada) **X** 100.

Source: National Population Health Survey, 1996/97, Statistics Canada, 1998.

86. TOBACCO CONTROL COMPLIANCE RATES BY REGION NOVA SCOTIA RETAILERS - 1997/98

Background: The percentage of retailers complying with the requirements of the Provincial Tobacco Access Act and the Federal Tobacco Act.

Formula: ((The total number of inspections - the number of retailers warned or charged) / the number of inspections) **X** 100.

Source: Tobacco Control Unit Annual Statistics, NSDoH.

87. HOME CARE NOVA SCOTIA

88. HOME CARE NOVA SCOTIA - ACCUMULATED ANNUAL CASELOAD - 1995/96 to 1997/98

Background: Caseload refers to a group of clients managed by one community based care coordinator. A client is admitted to the program when the client has been accepted at assessment, assessed by a care coordinator, assigned to a category, and service delivery (nursing, home support, personal care, oxygen services, or case management) has begun.

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[8] Ibid.

Formula: The accumulated total number of clients in the caseload for 1995/96, 1996/97, and 1997/98.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

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89. HOME CARE NOVA SCOTIA - NET PERCENTAGE CHANGE IN CASELOAD SINCE APRIL 1997 - By Region

Background: As stated above Caseload refers to a group of clients managed by one community based care coordinator. A client is admitted to the program when the client has been accepted at assessment, assessed by a care coordinator, assigned to a category, and service delivery (nursing, home support, personal care, oxygen services, or case management) has begun. This measure illustrates the amount to which the Home Care Nova Scotia clientele have grown in number as compared to the previous year for each Health Region.

Formula: (1 - (The number of clients in the caseload for the current year / the number of clients in the caseload for the previous year)) **X** 100. Where the figure '1' removes the clients who overlap from the previous year - indicating only net growth.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

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90. HOME CARE NOVA SCOTIA - 1997/98 - Number of Admissions by Quarter

Background: As stated above caseload refers to a group of clients managed by one community based care coordinator. A client is admitted to the program when the client has been accepted at assessment, assessed by a care coordinator, assigned to a category, and service delivery (nursing, home support, personal care, oxygen services, or case management) has begun. This measure is reported by quarter and Health Region.

Formula: The number of admissions to the Home Care Nova Scotia caseload on a quarterly basis by region.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

91. HOME CARE NOVA SCOTIA -1997/98 - Chronic Home Care Services Admissions by Quarter

Background: Chronic Home Care services provide home support, personal care, nursing, and home oxygen services to persons with assessed unmet needs who are convalescing, chronically ill, disabled, or experiencing debilities of old age. This measure is compared across the Health Regions.

Formula: The number of admissions to chronic Home Care services for the specified time period by region.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

92. HOME CARE NOVA SCOTIA- 1995/96 TO 1997/98 - Chronic Home Care Services Admissions - by Region

Background: Chronic Home Care services provide home support, personal care, nursing, and home oxygen services to persons with assessed unmet needs who are convalescing, chronically ill, disabled, or experiencing debilities of old age. This measure is compared across the Health Regions and over three years.

Formula: The number of admissions to chronic Home Care services for the specified time period by region.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

93. HOME CARE NOVA SCOTIA - 1997/98 - Acute Home Care Services Admissions by Quarter

Background: Acute Home Care services provide nursing services, and may provide personal care and/or home support services to meet the needs of individuals with acute episodic illness that may be treated safely and effectively within the home. Acute episodic illness is an illness or condition of short duration and relatively severe course which is a pronounced deviation from the normal state of health of the individual.

Formula: The number of admissions to acute Home Care services for a specified time period by region.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

94. HOME CARE - 1995/96 TO 1997/98 - Acute Home Care Services Admissions - by Region

Background: Acute Home Care services provide nursing services, and may provide personal care and/or home support services to meet the needs of individuals with acute episodic illness that may be treated safely and effectively within the home. Acute episodic illness is an illness or condition of short duration and relatively severe course which is a pronounced deviation from the normal state of health of the individual.

Formula: The number of admissions of acute Home Care services for a specified time period by region.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

95. HOME CARE NOVA SCOTIA 1997/98 - Number of Clients Receiving Home Oxygen

Background: "The home oxygen service funds clients of all ages with chronic hypoxemia who require a home oxygen concentrator. ... This service is intended to assist individuals who do not have the financial resources to secure a home oxygen concentrator necessary for more independent functioning in the home or home-like setting."[9] Home oxygen clients are generally admitted to chronic Home Care services.

Formula: The number of clients the receive home oxygen services by region.

Source: Monthly Provincial Statistics from Home Care Nova Scotia, NSDoH.

96. EMERGENCY HEALTH SERVICES

97. EMERGENCY HEALTH SERVICES - Government Subsidized Patient Transfers - by Distance 1997/98

Background: Patient transfers are recorded as local if the return trip is less than 160 kms and long distance if the return trip is greater than 160 kms. Data collection commenced the 7th. of February 1996.

Formula: The total number of patient transfers over long distance trips and local trips for each month of the fiscal year 1997/98.

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[9] Home Oxygen Service: Procedures and Guidelines, 2nd. Edition, February 1999, Home Care Nova Scotia, Nova Scotia Department of Health, page 4.

Source: Ambulance Subsidy System, AC830P01, NSDoH.

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98. EMERGENCY HEALTH SERVICES - Average Emergency / Urgent Call Processing and Response Times - 1998 - Nova Scotia - Rural and Urban

Background: The amount of time it takes for Emergency Health personnel to answer an emergency call, dispatch an emergency vehicle, and have the vehicle arrive at the scene of an emergency is of vital importance to the health and survival of the patient. The longer it takes emergency personnel to respond the greater the risk to the patient. Therefore the measurement of the amount of time it takes to receive a call and dispatch a vehicle and the amount of time it takes to receive the dispatch and arrive on scene is a measurement of the effectiveness of Emergency Health Services.

Formula: **Call Processing**: from the time an emergency call is received to the time of dispatch of closest vehicle and **Response Time**: from receiving the dispatch to arrival on scene. These measurements are made on each call and then averaged per month and per calender year.

Source: Communications Centre, Nova Scotia Emergency Health Services, NSDoH.

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99. EMERGENCY HEALTH SERVICES - Number of Calls and Number of Non-Emergency Transports - Urban and Rural - 1998 - Nova Scotia by Month

Background: One way to measure the utilization of Emergency Health Services Nova Scotia is to measure the use the vehicles get. In this case the measurement encompasses both emergency calls and non-emergency transports (patient transfers).

Formula: **Emergency Calls**: the total number of emergency calls per month and per calender year and **Non-Emergency Transports**: the total number of non-emergency transports per month and per calender year.

Source: Communications Centre, Nova Scotia Emergency Health Services, NSDoH.

100. EMERGENCY HEALTH SERVICES - Emergency Calls 'Top Ten' Chief Complaints - 1998 Nova Scotia Totals

Background: One way to determine equipment and skill requirements for each ambulance is to identify what the most frequently requested emergency services.

Formula: The total number of emergency / urgent calls by 'Chief Complaints' per month and per calender year.

Source: Communications Centre, Nova Scotia Emergency Health Services, NSDoH.

101. SURVIVAL RATES FOR OUT-OF HOSPITAL CARDIAC ARRESTS - For 1997 and 1998 with Year 2000 Target

Background: Persons suffering a cardiac arrest out of hospital have no chance of survival without resuscitation. Only through a combination of prompt Cardiopulmonary Resuscitation (CPR) and emergency services response with defibrillation can people be saved from certain death. Therefore advanced pre-hospital care provided by an emergency health system increases the chance of survival of those who suffer a cardiac arrest outside of hospital. Note: survival rates refers only to patients who are discharged from hospital neurologically intact.

Formula: (The number of neurologically intact survivors of out-of-hospital cardiac arrests who were treated by NSEHS / the total numbers of persons suffering out-of-hospital cardiac arrests who were treated by EHSNS) X 100.

Source: Nova Scotia Emergency Health Services, NSDoH.

102. SERVICE EXPENDITURES

103. MEDICARE - EXPENDITURES FOR INSURED SERVICES - Total Expenditures on All Insured Services - Excludes Administrative Expenses

Background: Insured services include Medicare, Denticare (childrens' and in-hospital surgical procedures), and Pharmacare. The measure of total expenditures refers to the total amount of money spent on these services. Data are on a "Date of Payment" basis.

Formula: Total expenditures on insured services per fiscal year as expressed in millions of dollars.

Excl: This measure excludes services provided to members of the Royal Canadian Mounted Police (RCMP) and Armed Forces personnel, as their services are funded federally. Administrative expenditures, CMPA (Fee-For-Service) , Benefit Funds (Fee-For-Service) , and Co-pay are excluded.

Source: MSI Annual Statistical Tables, NSDoH Health Economics, NSDoH.

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104. MEDICARE - NUMBER OF PHYSICIAN SERVICES PER BENEFICIARY - 1990/91 to 1997/98

Background: This measure expresses the services that Physicians provide per benefactor (insured person who receives services) . The insured population refers to those that have a Nova Scotia Health Card. Data are on a "Date of Payment" basis.

Formula: The total number of physician services rendered / the total benefitting - insured population of Nova Scotia.

Incl: This measure includes salaried, Quebec and out-of-province billing, and reciprocal billing (Reciprocal billing is an agreement between 9 Canadian provinces and the two territories where each province bills the patient's home province for physicians' services and, is the amount paid for Nova Scotia residents for physician services received while the resident was outside Nova Scotia. Services for Nova Scotia residents while in Quebec and out-of-country are not included in this agreement).

Excl: This measure excludes those services provided to members of the Royal Canadian Mounted Police (RCMP) and Armed Forces personnel, as their services are funded federally. Administrative expenditures and shadow billing (dummy claims submitted by salaried physicians to provide patient service information) are not included in this measure.

Source: MSI Annual Statistical Tables, NSDoH Health Economics, NSDoH.

105. MEDICARE - PHYSICIAN SERVICES EXPENDITURES PER BENEFICIARY 1990/91 to 1997/98

Background: This measure illustrates the amount of money expended on services on a per beneficiary basis (a beneficiary is an insured person who receives services). The insured population refers to those that have a Nova Scotia Health Card. Data are on a "Date of Payment" basis.

Formula: The total amount of money spent on services / the total insured population receiving services (beneficiary) .

Incl: This measure includes salaried, Quebec and out-of-province billing, and reciprocal billing (Reciprocal billing is defined as an agreement between 9 Canadian provinces and the two territories where each province bills the province of the patient for physicians' services and, is the amount paid for Nova Scotia residents for physician services received while the resident was outside Nova Scotia. Services for Nova Scotia residents while in Quebec and out-of-country are not included in this agreement).

Excl: This measure excludes those services provided to members of the Royal Canadian Mounted Police (RCMP) and Armed Forces personnel, as their services are funded federally. Administrative expenditures and shadow billing (dummy claims submitted by salaried physicians to provide patient service information) are not included in this measure.

Source: MSI Annual Statistical Tables, NSDoH Health Economics, NSDoH.

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106. MEDICARE - POPULATION PER GENERAL PRACTITIONER (GP) - Fee-for-Service Only - The Total Number of Insured Population to General Practitioners in Nova Scotia - 1990/91 to 1997/98

Background: A general practitioner is a licensed general practice physician who receives at least one dollar per year. This measure shows the number of insured people for every one general practitioner in the province.

Formula: The number of general practitioners in Nova Scotia / the total number of insured population per fiscal year.

Source: MSI Database, NSDoH Health Economics, NSDoH.

107. MEDICARE - NUMBER OF GENERAL PRACTITIONERS (GP's) - By Location: Urban, Rural, and Total - for 1990/91 to 1997/98 - Nova Scotia

Background: A general practitioner is a licensed general practice physician who receives at least one dollar per year. This measure illustrates the number of insured people for every one general practitioner in the province. "Urban areas are defined as areas with a population over 35,000. These areas include: Sydney Urban area within a perimeter bounded by North Sydney, Sydney City, and Glace Bay; The Halifax/Dartmouth area [is] within a perimeter bounded by Halifax, Middle Sackville, and Dartmouth."[10]

Formula: The number of general practitioners in Nova Scotia by location and fiscal year.

Source: MSI Database, NSDoH Health Economics, NSDoH.

108. PHARMACARE - NUMBER OF PRESCRIPTIONS PER BENEFICIARY - Nova Scotia 1990/91 to 1997/98

Background: This indicator illustrates the number of prescriptions paid under Pharmacare for every insured person who has received benefits (beneficiary) . The insured population comes from the health card file from which those who have received benefits are drawn (beneficiary population) . Data are on a "Date of Payment" basis.

Formula: The total number of prescriptions paid for by Pharmacare / the total number of Nova Scotian insured persons who have received benefits (beneficiary).

Encl: This measure excludes nursing home residents where their facility supplies prescriptions. It further excludes those services provided to members of the Royal Canadian Mounted Police (RCMP) and Armed Forces personnel, as their services are funded federally.

Source: MSI annual statistical tables, NSDoH Health Economics, NSDoH.

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[10] Footnote 2, Table 3.0 (continued) : Physicians' Services' Fee-For-Service Payments by Speciality in Urban and Rural Areas 1995/96 and 1996/97, Insured Programs Management, Nova Scotia Department of Health, Draft Copy. Bracketed additions were added by the Health Information and Evaluation Section, Nova Scotia Department of Health.

109. PHARMACARE - AMOUNT PAID FOR PRESCRIPTIONS PER BENEFICIARY - Nova Scotia 1990/91 to 1997/98

Background: This indicator illustrates the dollar amount for prescriptions paid under Pharmacare per beneficiary (a beneficiary is an insured person who has received benefits). The insured population comes from the health card file from which those who have received benefits are drawn (beneficiary population). Data are on a "Date of Payment" basis.

Formula: The total amount spent on prescriptions by Pharmacare / the total number of Nova Scotian insured persons who have received benefits (beneficiaries).

Incl: This measure includes co-pay adjustments and reimbursements.

Excl: This measure excludes co-pay amounts. Nursing home residents, where their facility supplies prescriptions, are excluded. It further excludes those services provided to members of the Royal Canadian Mounted Police (RCMP) and Armed Forces personnel, as their services are funded federally.

Source: MSI annual statistical tables, NSDoH Health Economics, NSDoH.

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110. DENTICARE - PERCENTAGE OF CHILDREN RECEIVING ANNUAL DENTAL CHECK-UPS - 3 to 9 Years of Age

Background: This measure illustrates the number of children (ages 3 to 9 years) receiving annual check-ups covered under the Children's Dental Care Program Denticare program) as expressed as a percentage of all insured children (ages 3 to 9 years) per fiscal year. An annual check-up includes an annual check-up and/or recall exam.

Formula: (The number of children (ages 3 to 9 years) receiving annual check-ups covered under Denticare / the total number of insured Nova Scotian children (ages 3 to 9 years)) **X** 100 per fiscal year.

Source: MSI Database, NSDoH Health Economics, NSDoH.

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111. DENTICARE - PERCENTAGE OF CHILDREN RECEIVING ANNUAL DENTAL CHECK-UPS - 3 to 9 Years of Age by Region of Residence - 1997/98

Background: This measure illustrates the number of children (ages 3 to 9 years who are covered under the Children's Dental Care Program (Denticare program)) receiving annual check-ups as expressed as a percentage of all insured children (ages 3 to 9 years). The measure is also shown for all Health Regions in 1997/98. An annual check-up includes an annual check-up and/or recall exam.

Formula: (The number of children (ages 3 to 9 years) receiving annual check-ups covered under Denticare / the total number of insured Nova Scotian children (ages 3 to 9 years)) **X** 100 per Health Region.

Source: MSI Database, NSDoH Health Economics, NSDoH.

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112. DENTICARE - AVERAGE NUMBER OF DENTAL RESTORATIONS PER INSURED - 3 to 9 Years of Age

Background: This measure illustrates the number of children (ages 3 to 9 years who are covered under the Children's Dental Care Program (Denticare program)) receiving dental restorations as expressed as a percentage of all insured children (ages 3 to 9 years). The measure is expressed per fiscal year.

Formula: The number of children (ages 3 to 9 years) receiving dental restorations covered under Denticare / the total number of insured Nova Scotian children (ages 3 to 9 years)) **X** 100 per fiscal year.

Source: MSI Database, NSDoH Health Economics, NSDoH.

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113. DENTICARE - AVERAGE NUMBER OF DENTAL RESTORATIONS PER INSURED - 3 to 9 Years of Age by Region of Residence

Background: This measure illustrates the number of children (ages 3 to 9 years who are covered under the Children's Dental Care Program (Denticare program)) receiving dental restorations as expressed as a percentage of all insured children (ages 3 to 9 years) . The measure is further expressed per Health Region in 1997/98.

Formula: (The number of children (ages 3 to 9 years) receiving dental restorations covered under Denticare / the total number of insured Nova Scotian children (ages 3 to 9 years)) **X** 100 per Health Region.

Source: MSI Database, NSDoH Health Economics, NSDoH.

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114. WOMEN'S HEALTH

115. CAESAREAN SECTIONS PER 100 DELIVERIES - Nova Scotia and Canada 1970/71 to 1997/98

Background: This indicator measures the rate of performance of caesarean sections expressed a percentage of all deliveries by the women's Region of residence. The following Case Mix Groups (CMG's) 600 to 604 were used for caesarean sections and 600 to 604 and 606 to 611 were used for deliveries.

Formula: (The total number of caesarean sections by the women's Region of residence / the total number of deliveries in Nova Scotia per Region) **X** 100 per fiscal year.

Source: Health Reports, Statistics Canada, for Canadian and Nova Scotia data, 1969 to 1993/94; NSDoH ASD System 1989/90 to 1994/95; CIHI DAD 1995/96, 1997/98, NSDoH.

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116. CAESAREAN SECTION RATE - By Region of Hospitalization - Nova Scotia 1997/98

Background: This indicator measures the rate of performance of caesarean sections expressed a percentage of all deliveries by the women's Region of hospitalization. The following Case Mix Groups (CMG's) 600 to 604 were used for caesarean sections and 600 to 604 and 606 to 611 were used for deliveries. The provincial target is set to a maximum of 20%.

Formula: (The total number of caesarean sections by the women's Region of hospitalization / the total number of deliveries in Nova Scotia per Region) **X** 100 per fiscal year.

Source: NSDoH CIHI DAD, NSDoH.

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117. MAMMOGRAPHY SCREENING PROVINCE-WIDE RATE - Percentage of Women Screened (Aged 50 to 69 Years) - 1991/92 to 1997/98

Background: This indicator measures the number of women ages 50 to 69 who have had at least one mammogram for breast cancer screening in a given fiscal year, as administered by the Nova Scotia Breast Screening Program. The Nova Scotia Breast Screening Program has mobile screening vans in the Eastern and Western Regions. The data for this indicator are province wide.

Formula: (The total number of women ages 50-69 who have had one mammogram during a fiscal year (new recruits) / the yearly Nova Scotia population estimate (for example 1997 estimate) women ages 50-69) **X** 100 per fiscal year.

Note: The Nova Scotia Breast Screening Program terms the number of mammograms as 'new recruits' in their literature.

Source: Nova Scotia Breast Screening Program database, NSDoH, especially the Nova Scotia Breast Screening Program: Fiscal Report 1997-1998, October 1998, Nova Scotia Department of Health.

118. BREAST CANCER MORTALITY RATES - Nova Scotia and Canada - 1950 to 1997 Age-Standardized Rates per 100,000 of the Female Population

Background: The mortality rate of breast cancer for women shows the rate at which women have died from breast cancer.

Formula: ((The number of women who died from breast cancer in Nova Scotia / the population estimate in Nova Scotia) **X** Standardizing Process) **X** 100,000 per calender year.

Note: The population estimates for Nova Scotia from 1990 to 1997 were the most current available from Statistics Canada as of September 1998. The standardizing population (Canada 1991) is used for both data sources.

Source: For 1950 to 1990 Nova Scotia and 1950 to 1992 Canada - Health Indicators Database, Statistics Canada, 1996; for Nova Scotia from 1990 to 1997 - Nova Scotia Vital Statistics 1990 to 1997 and Health Information and Evaluation Section; NSDoH.

119. NOVA SCOTIA GYNECOLOGICAL CANCER SCREENING PROGRAM - Percentage of Women Screened - PAP Test - (15 Plus Years of Age) - 1995 to 1997 by Region

Background: Cancer of the cervix is largely preventable through appropriate detection and the PAP test is an effective screening tool. The PAP screening test is used in the secondary prevention of cervical cancer. The Nova Scotia Gynecological Cancer Screening Program receives copies of the results of all Pap smear tests performed in Nova Scotia. A registry has been developed that allows the Program to track the frequency of testing, to identify and track high risk patients, and to encourage follow-up by individual physicians whose patients are at a higher risk of developing cervical cancer.

Formula: (The number of women 15 years of age and older receiving the PAP screening test per calender year / Nova Scotia Provincial Cytology Registry Target Population per year) **X** 100 per Health Region.

Note: Each woman must be matched to a Nova Scotia county in order to be included in the target population and PAP test counts.

Source: Provincial Cytology Registry, Nova Scotia Gynaecological Cancer Screening Program, 1995, 1996, and 1997, NSDoH.

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120. CERVICAL CANCER INCIDENCE RATES - Nova Scotia 1971 to 1997

Background: Incidence rate trends associated with cervical cancer can provide important planning information regarding treatment and prevention programs, especially as death from chronic conditions becomes more prevalent.

Formula: ((The number of women who were diagnosed with cervical cancer (new cases) in Nova Scotia / the population estimate in Nova Scotia) **X** Standardizing Process) **X** 100,000 per calender year.

Source: Nova Scotia Cancer Registry, NSDoH.

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121. CERVICAL CANCER MORTALITY RATES - Nova Scotia and Canada - 1990 to 1997

Background: Mortality rate trends associated with cervical cancer can provide important planning information regarding treatment and prevention programs, especially as death from chronic conditions becomes more prevalent.

Formula: ((The number of women who died from cervical cancer in Nova Scotia / the population estimate in Nova Scotia) **X** Standardizing Process) **X** 100,000 per calender year.

Source: Nova Scotia Vital Statistics and Health Information and Evaluation Section, NSDoH for the Nova Scotia data and Canadian Cancer Statistics for the Canadian data.

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122. MORTALITY IN NOVA SCOTIA

Note: ***The following slides use the same methodology for each case so there will only be one definition for all the slides in this section.***

123. **HEART DISEASE - Nova Scotia - by Region of Residence - Age-Standardized Mortality Rate per 100,000 Population**

124. **RESPIRATORY DISEASES - Nova Scotia - by Region of Residence - Age-Standardized Mortality Rate per 100,000 Population**

125. **ALL MALIGNANT NEOPLASMS - Nova Scotia - by Region of Residence - Age-Standardized Mortality Rate per 100,000 Population**

126. **COLORECTAL CANCER - Nova Scotia - by Region of Residence - Age-Standardized Mortality Rate per 100,000 Population**

127. **LUNG CANCER (INCLUDING TRACHEA AND BRONCHUS) - Nova Scotia - by Region of Residence - Age-Standardized Mortality Rate per 100,000 Population**

128. **ALL ACCIDENTS, INJURIES, AND POISONINGS - Nova Scotia - by Region of Residence - Age-Standardized Mortality Rate per 100,000 Population**

129. **ALL TRAUMATIC ACCIDENTAL CAUSES - Nova Scotia - by Region of Residence - Age-Standardized Mortality Rate per 100,000 Population**

130. **ALL CAUSE MORTALITY - Nova Scotia - by Region of Residence - Age-Standardized Mortality Rate per 100,000 Population**

Background: Mortality rate trends associated with various causes of illness or injury provide important planning information regarding treatment and prevention programs, especially as death from chronic conditions becomes more prevalent.

ICD-9-CM Code Ranges: **Heart Disease** - 391 to 391.99, 392 to 392.99, 393 to 398.99, 402 to 402.99, 404 to 404.99, 410 to 416.99, and 420-429.99; **Respiratory Disease** - 460 to 519.99; **All Malignant Neoplasms** - 140 to 208.99; **Colorectal Cancer** - 153 to 154.99; **Lung Cancer (Including Trachea and Bronchus)** - 162 to 162.99; **All Accidents, Injuries, and Poisonings** - E800 to E999.99; **All Traumatic Accidental Causes** - E000 to E849.99; and **All Cause Mortality** - 001 to E999.99.

Formula: ((The number of Nova Scotians who died from a given aliment in Nova Scotia / the population estimate in Nova Scotia) **X** Standardizing Process) **X** 100,000 per calender year.

Note: The population estimates from the Health Information and Evaluation Section place Hants county completely in the Central Region.

Source: Nova Scotia Vital Statistics, NSDoH and Health Information and Evaluation Section, NSDoH.

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131. PROCEDURE RATE VARIATIONS

Note: ***The following slides use the same methodology for each case so there will only be one definition for all the slides in this section.***

132. LAPAROSCOPIC CHOLECYSTECTOMY [51.23] - Age-Standardized Rate per 1,000 Population - Nova Scotia per County - 1997/98

133. ESOPHAGOGASTRODUODENOSCOPY [44.13 to 44.14; 45.13 to 45.14; and 45.16] - Age- Standardized Rate per 1,000 Population - Nova Scotia per County - 1997/98

134. BILATERAL MYRINGOTOMY AND TUBES [20.01] - Age-Standardized Rate per 1,000 Population - Nova Scotia per County - 1997/98

135. COLONOSCOPY [45.23 and 45.25] - Age- Standardized Rate per 1,000 Population - Nova Scotia per County - 1997/98

136. CHOLECYSTECTOMY, ANY TECHNIQUE [51.22 to 51.23] - Age- Standardized Rate per 1,000 Population - Nova Scotia per County - 1997/98

137. CATARACT EXTRACTION WITH SIMULTANEOUS LENS INSERTION [13.11 to 13.72] - Age- Standardized Rate per 1,000 Population - Nova Scotia per County - 1997/98

138. CORONARY ARTERY BYPASS GRAFTING [36.10 to 36.19] - Age- Standardized Rate per 1,000 Population - Nova Scotia per County - 1997/98

139. VAGINAL AND ABDOMINAL HYSTERECTOMIES [68.3 to 68.9] - Age- Standardized Rate per 1,000 Population - Nova Scotia per County - 1997/98

Background: Small area variation data gives an insight into the incidence of certain conditions in a particular population, but more typically the prevailing pattern of medical practice. Since the rates are based on patient residence rather than site of treatment, the data reflects referral patterns as well. Wide variations in rates may prompt an evaluation of the clinical criteria being applied for access to the procedure. ICD-9-CM procedure codes were used.

Formula: ((The number of procedures done per county in Nova Scotia / the population estimate per county in Nova Scotia) **X** Standardizing Process) **X** 100,000 per fiscal year.

Source: NSDoH CIHI DADS, NSDoH and Health Information and Evaluation Section, NSDoH.

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140. SLIDE INDICES

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